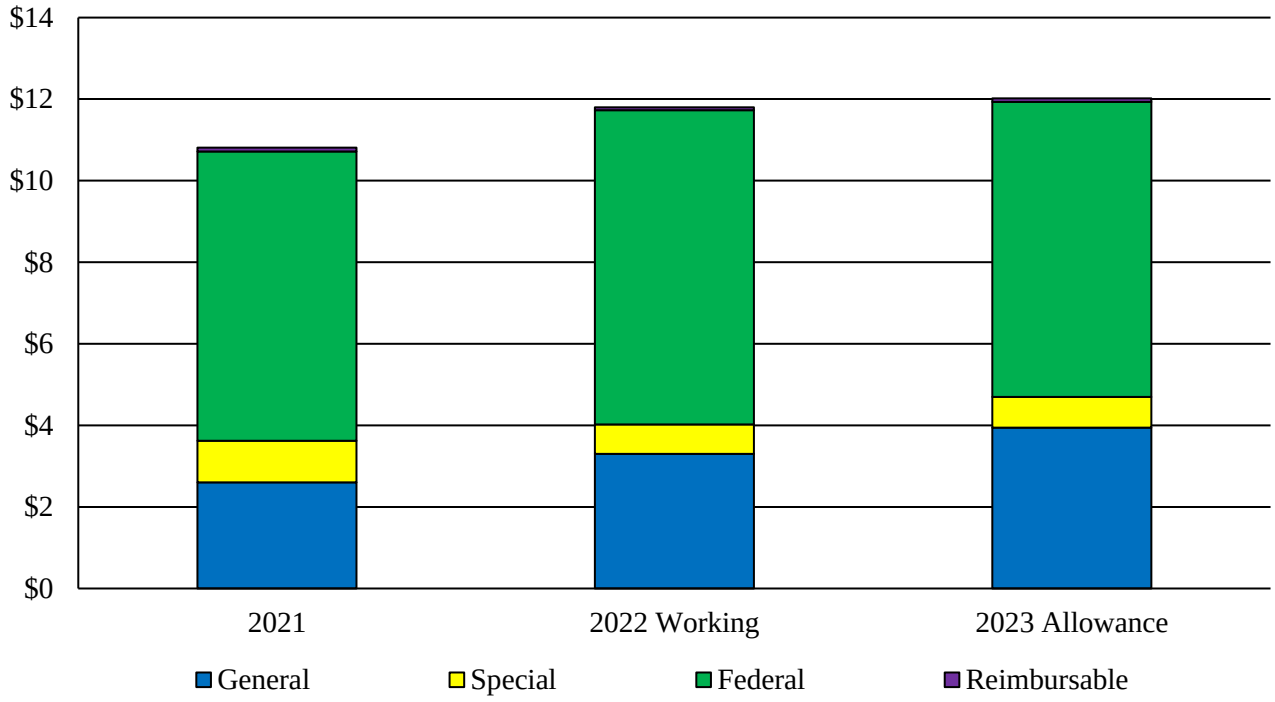
M00Q01
Medical Care Programs Administration
Maryland Department of Health

Executive Summary

The Medical Care Programs Administration (MCPA) within the Maryland Department of Health (MDH) is responsible for administering the Medical Assistance Program (Medicaid) and the Maryland Children's Health Program (MCHP) that provide comprehensive health benefits to over 1.6 million Marylanders. MCPA administers various other programs including specialty mental health and substance use disorder (SUD) services for Medicaid recipients.

Operating Budget Summary

Fiscal 2023 Budget Increases $218.3 Million, or 1.8%, to $12.0 Billion
($ in Billions)



Note: The fiscal 2022 working appropriation includes proposed deficiencies, including those appropriated through Supplemental Budget No. 1, and targeted reversions. The fiscal 2022 working appropriation and fiscal 2023 allowance do not reflect funding for statewide personnel actions budgeted in the Department of Budget and Management, which include cost-of-living adjustments, increments, bonuses, and annual salary review adjustments.

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- The growth in the fiscal 2023 allowance fully funds mandated provider rate increases, supports physician and dental rate increases, and expands slots in existing programs, such as the Home and Community-based Options Waiver (Community Options), the Assistance in Community Integration Services pilot program, and the Employed Individuals with Disabilities (EID) Program. These enhancements are partially offset by declining enrollment and utilization.

- General funds increase by approximately $645.0 million, or 19.5%, in the fiscal 2023 allowance compared to fiscal 2022 after accounting for funds allocated through Supplemental Budget No. 1, deficiency appropriations, and the targeted reversion. This increase predominantly backfills enhanced federal matching funds received in fiscal 2022 during the nationally declared COVID-19 public health emergency (PHE). The COVID-19 PHE was extended into the final quarter of fiscal 2022, providing the State with additional enhanced federal matching funds through the end of fiscal 2022. The adjusted fiscal 2022 budget accounts for a full year of this enhanced match.

Key Observations

- ***Medicaid Budget Includes Pandemic-related Aid, Mainly Supported with Federal Funds:*** MDH has received and expects to continue receiving enhanced federal matching funds from multiple sources supporting a variety of services and qualifying expenses, such as home- and community-based services (HCBS) and vaccine administration costs. Other sources of aid within Medicaid include State-funded incentive payments to improve vaccination rates among Medicaid recipients and federal grant funding for nursing homes and adult medical day care (AMDC) facilities.

- ***MDH Receives Federal Approval for Section 1115 HealthChoice Waiver Renewal:*** Effective January 1, 2022, the State's 1115 waiver was renewed for five years. The department's approved waiver renewal also implemented new programs, such as the Emergency Triage, Treat, and Transport (ET3) Model; expansion of Institutions of Mental Disease (IMD) Services for Adults with Serious Mental Illness (SMI); and the Maternal Opioid Misuse (MOM) Model.

- ***Value-based Purchasing (VBP) Program Transitions to Incentive Only Population Health Incentive Program:*** Since 1997, MDH implemented a pay-for-performance program called the VBP program to improve managed care organization (MCO) performance through monetary incentives and disincentives. Due to recent concerns regarding the structure of VBP payments, this program sunset on December 31, 2021, and was replaced with the new Population Health Incentive Program (PHIP) with an incentive-only structure.

Operating Budget Recommended Actions

		Funds
1.	Add language restricting funds for the purpose of administration until the Maryland Department of Health submits quarterly reports with data and status updates related to the Medicaid redetermination process.	
2.	Add language restricting funds for the purpose of administration until the Maryland Department of Health submits a report on home- and community-based services expansion.	
3.	Add language restricting provider reimbursement funding to that purpose.	
4.	Adopt narrative requesting a report on calendar 2020 and 2021 managed care organization risk corridor settlements.	
5.	Adopt narrative requesting quarterly reports on Community First Choice Program and Home- and Community-based Options Waiver financial and registry data.	
6.	Add language restricting program expenditures under the Maryland Children's Health Program to that purpose.	
7.	Delete a fiscal 2022 federal fund deficiency appropriation under Medicaid that is double budgeted.	$37,427,995
8.	Delete a fiscal 2022 federal fund deficiency appropriation under the Maryland Children's Health Program that is double budgeted.	350,973
	Total Reductions to Fiscal 2022 Deficiency Appropriation	**$37,778,968**

Updates

- ***Medicaid Expenditures on Abortion****:* Annual data on abortion services are provided.

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Operating Budget Analysis

Program Description

MCPA, a unit of MDH, is responsible for administering Medicaid, MCHP, the Family Planning Program, the EID program, and the Senior Prescription Drug Assistance Program (SPDAP). MCPA also oversees expenditures for fee-for-service (FFS) Medicaid-eligible community behavioral health services for Medicaid-eligible recipients. However, that funding is included in the MDH Behavioral Health Administration (BHA) analysis. In addition, in fiscal 2021, the Kidney Disease Program (previously part of MCPA) was transferred by budget amendment to the MDH Prevention and Health Promotion Administration.

Medicaid

Medical Assistance (Title XIX of the Social Security Act) is a joint federal and state program that provides assistance to indigent and medically indigent individuals. In Maryland, the federal government generally covers 50% of Medicaid costs. Medical Assistance eligibility is limited to children, pregnant women, elderly or disabled individuals, low-income parents, and childless adults. To qualify for benefits, applicants must pass certain income and asset tests.

Income eligibility levels can vary, for example, based on the individual's age and pregnancy status. Individuals qualifying for cash assistance through the Temporary Cash Assistance Program or the federal Supplemental Security Income (SSI) program automatically qualify for Medicaid benefits. The U.S. Congress has extended eligibility to include pregnant women and children who meet certain income eligibility standards through the Pregnant Women and Children Program. Federal law also requires the Medicaid program to assist Medicare recipients with incomes below the federal poverty level (FPL) in making their coinsurance and deductible payments. Effective January 1, 2014, Medicaid coverage was expanded to persons below 138% of FPL, as authorized in the Affordable Care Act (ACA). The federal match for this population in fiscal 2022 is 90%. The most current FPL guidelines are listed in **Appendix 4**.

Another major group of Medicaid-eligible individuals is the medically needy. The medically needy are individuals whose income exceeds categorical eligibility standards but are below levels set by the State. People with incomes above the medically needy level may reduce their income to the requisite level through spending on medical care.

Medicaid funds a broad range of services. The federal government mandates that the State provide nursing facility services; hospital inpatient and outpatient services; x-ray and laboratory services; early and periodic screening, diagnosis, and treatment services for children; family planning services; transportation services; physician care; federally qualified health center and rural health clinic services; and some nurse practitioner services. The federal government also allows optional services

that Maryland provides, including vision care, podiatric care, pharmacy, medical supplies and equipment, intermediate-care facilities for the developmentally disabled, and institutional care for people over the age of 65 with mental diseases.

Most Medicaid recipients are required to enroll in HealthChoice, which is the name of the statewide mandatory managed care program that began in 1997. Populations excluded from the HealthChoice program are covered on an FFS basis, and the FFS population generally includes the institutionalized and individuals who are dually eligible for Medicaid and Medicare.

MCHP

MCHP is Maryland's name for medical assistance for low-income children with household income that exceeds income eligibility for Medicaid. The State is normally entitled to receive 65% federal financial participation for children in this program. Those eligible for the higher match are children under the age of 19 living in households with an income below 300% of FPL but above the Medicaid eligibility level. MCHP provides all of the same services as Medicaid. A premium of about 2% of family income is required of child participants with family incomes above 200% of FPL. It should be noted that Governor Lawrence J. Hogan, Jr. has suspended monthly premium payments during the national declaration of a COVID-19 PHE.

Family Planning

The Family Planning Program provides medical services related to family planning for women who lose Medicaid coverage after they were covered for a pregnancy. Covered services include medical office visits; physical examinations; certain laboratory services; family planning supplies; reproductive education, counseling, and referral; and tubal ligation. Coverage for family planning services continues until the age of 51 with annual redetermination unless the individual becomes eligible for Medicaid or MCHP, no longer needs birth control due to permanent sterilization, no longer lives in Maryland, or is income-ineligible (above 250% of FPL). Chapters 464 and 465 of 2018 required the department to include family planning services in the State Plan (the formal agreement between the federal government and a state on how the state intends to administer the Medicaid program) as opposed to under a waiver that would, among other things, maintain current income eligibility, remove age limitations, and establish a presumptive eligibility process for enrollment in the program.

EID Program

The EID program extends medical assistance to working Marylanders with disabilities. Also known as the Medicaid Buy-in, this program lets disabled individuals return to work while maintaining health benefits by paying a small fee. Individuals eligible for the EID program may make more money or have more resources than other Medicaid programs in Maryland. The services available to EID enrollees are the same as the services covered by Medicaid. The federal government covers 50% of the cost for the EID program.

SPDAP

SPDAP provides Medicare Part D premium assistance to offset costs for moderate-income (at or below 300% of FPL) Maryland residents who are eligible for Medicare and are enrolled in certain Medicare Part D Prescription Drug Plans.

Performance Analysis: Managing for Results

1. Measures of MCO Quality Performance

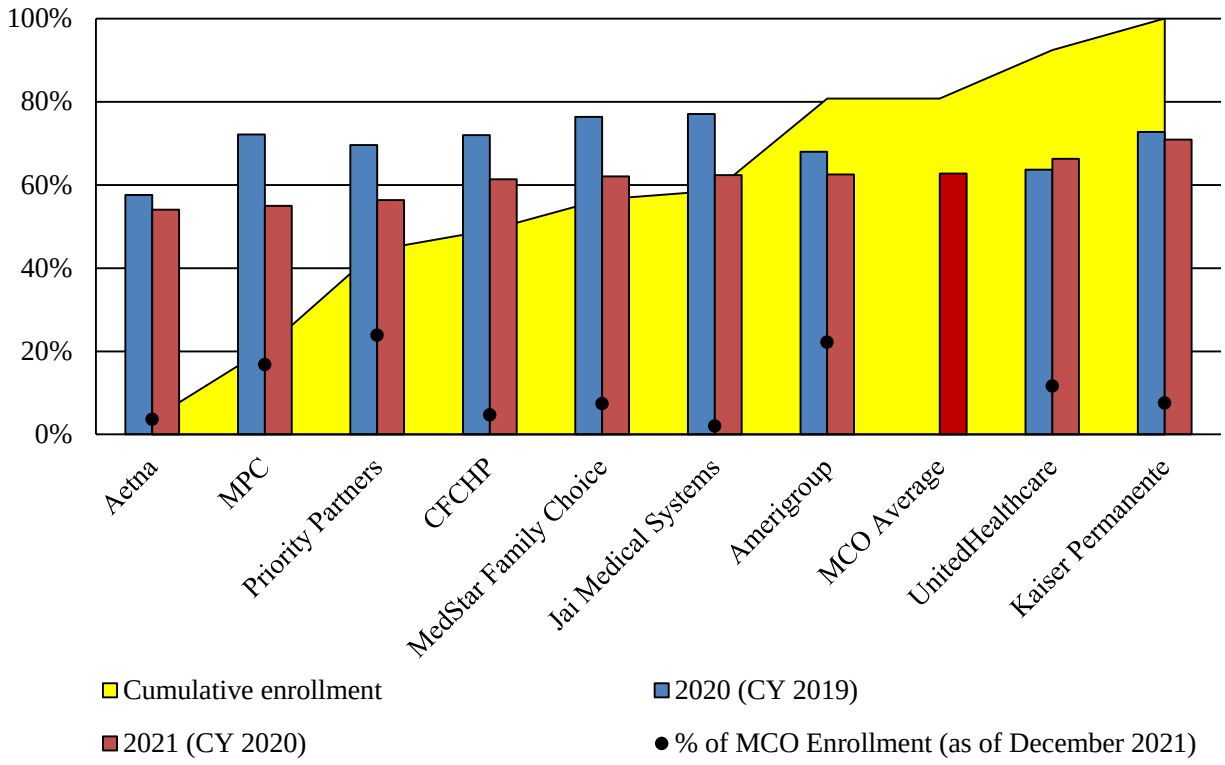
MDH conducts numerous activities to review the access to, and quality of, services provided by the MCO participating in HealthChoice. One such activity is the review of the Healthcare Effectiveness Data and Information Set (HEDIS). HEDIS is developed by the National Committee for Quality Assurance (NCQA) to measure health plan performance for comparison among health systems. This tool is used by more than 90% of health plans across the country.

The HEDIS data collected by MDH in calendar 2020 included 46 measures across multiple quality domains (for example, effectiveness of care and access or availability of care) and consumer assessment scores. Some measures have multiple components. A slightly smaller set of measures/components than those actually collected are used by the department for MCO quality monitoring. The data presented below is generally drawn from the larger data set and consists of 94 measures. Therefore, MDH's performance monitoring results in calendar 2020 differ from the information shown in this analysis as multiple measures are excluded.

Exhibit 1 shows the percentage of measures at or above the national HEDIS mean for those components for which a national HEDIS mean was available and an individual MCO had a HEDIS score. Historically, Maryland's MCOs collectively outperform their peers nationally. In calendar 2020, Maryland MCOs reached or surpassed the national HEDIS mean on 62.8% of HEDIS measures collected by MDH. Despite these overall positive outcomes, almost all MCOs reported a decline in the percent of their outcomes meeting or surpassing the national mean compared to calendar 2019. The three highest performing MCOs in calendar 2019, (Jai Medical Systems, MedStar Family Choice, and Maryland Priority Partners) experienced especially large decreases in performance and fell below the MCO average in calendar 2020. Only UnitedHealthcare reported a slight improvement of 2.6 percentage points, rising from 64% to 66% of measures.

The exhibit also shows the relative and cumulative shares of MCO enrollment as of December 2021, demonstrating that 80.8% of HealthChoice enrollees are served in MCOs that fell below the State average performance. However, the relative spread of enrollees across the highest and lowest performing MCOs is even for calendar 2020 performance as the two MCOs performing better than the State's average (UnitedHealthcare and Kaiser Permanente) serve 19.2% of enrollees combined, while the bottom two performing MCOs serve 20.5% of HealthChoice enrollees.

Exhibit 1
Percent of Measures Equal to or Above National HEDIS Mean and Shares of MCO Enrollment
Calendar 2019 to 2020, Enrollment as of December 2021



CFCHP: CareFirst Community Health Plan
CY: calendar year
HEDIS: Healthcare Effectiveness Data and Information Set
MCO: managed care organization
MPC: Maryland Physicians Care

Note: A number of the HEDIS measures/components used in this analysis were not applicable to certain MCOs based on the small number of patients included in the measure/component. For the purpose of calculating relative performance, those measures are excluded for that MCO. CFCHP acquired University of Maryland Health Partners (UMHP), therefore CFCHP presents data that was labeled as UMHP in prior years.

Source: Maryland Department of Health; MetaStat, Inc.; Hilltop Institute; Department of Legislative Services

Since 2013, MCOs must be accredited by NCQA to participate in the HealthChoice Program. Accreditation was required within two years for existing MCOs and is required within two years of program entry for new MCOs. NCQA formerly used a tiered structure of accreditation levels ranging from "denied" at the lowest level to "excellent" at the highest level. These levels were determined

through a 100-point system valuing certain standards, performance, and consumer experience. Beginning in the 2020 Health Plan Accreditation standards year, performance scoring is separate from standards scoring, and MCOs will receive a rating and accreditation. All nine Maryland MCOs were granted accreditation in 2020.

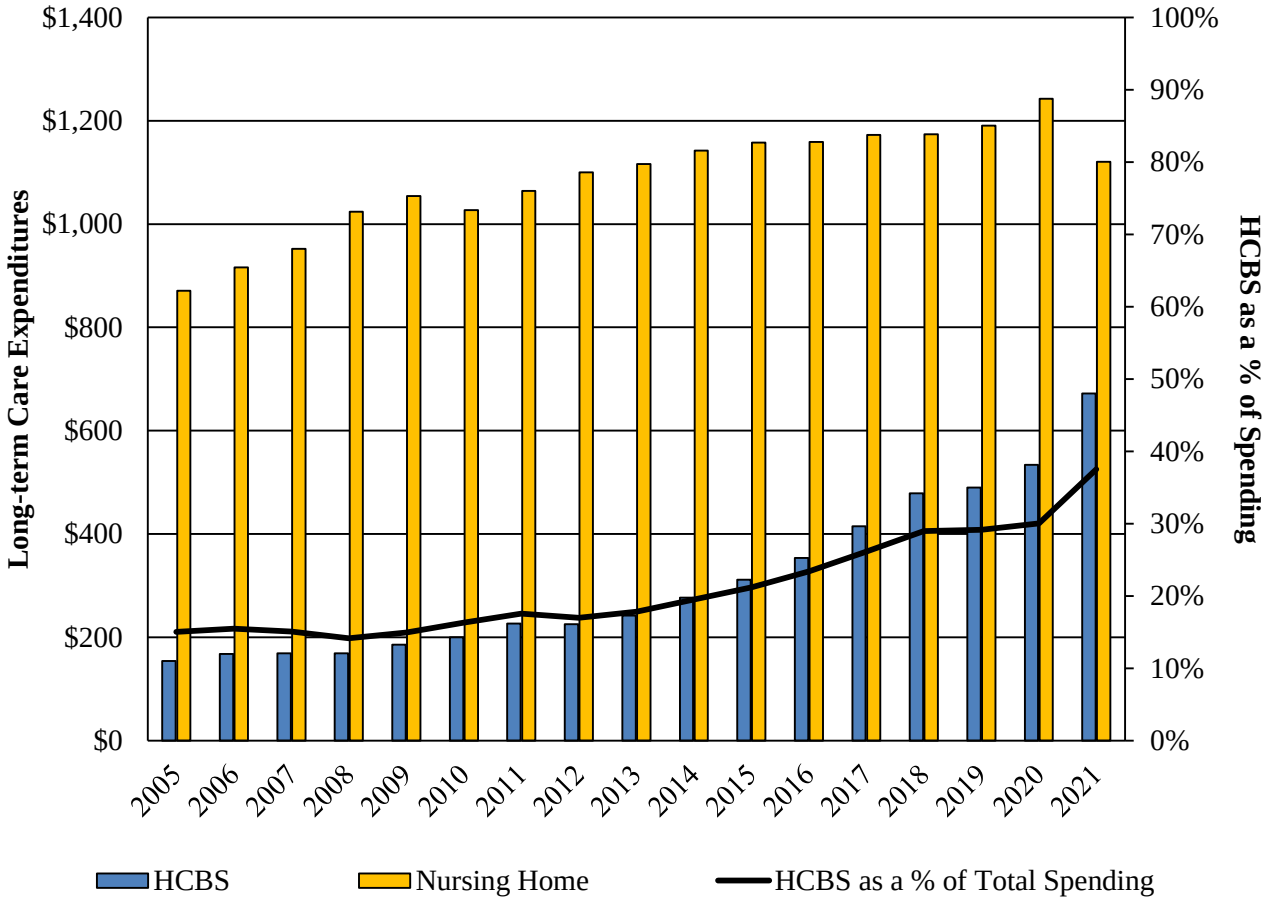
2. Rebalancing among HCBS and Institutional Care

In recent years, the Medicaid program has devoted considerable effort to rebalancing long-term care services away from institutional care (nursing homes) to community-based settings. Much of the rebalancing effort has been underwritten by the availability of enhanced federal funding in the ACA, including the Balancing Incentive Payment Program (enhanced funding that ended in fiscal 2016), the Community First Choice (CFC) program, and funding through the Money Follows the Person program. Research has shown that individuals generally prefer living in community-based settings. Additionally, there is evidence that use of HCBS care reduces the risk of institutional care, reduces levels of family stress, and improves the quality of life for individuals served in those community-based settings. Further discussion of efforts to expand HCBS waiver programs can be found in the MDH Overview analysis.

While serving an individual in HCBS as a direct alternative to institutional care is cheaper, studies evaluating the cost to states of expanding access to HCBS have produced mixed results. Further, evidence points to savings from such initiatives accruing to Medicare (a federally funded only program) rather than to Medicaid. Narrative in the 2021 *Joint Chairmen's Report* (JCR) requested a report on HCBS waiver expansion specifying programmatic recommendations on ways to claim Medicare savings to apply to costs for HCBS expansion. As of February 20, 2022, this report had not been submitted.

As shown in **Exhibit 2**, long-term care expenditures reflect this shift toward HCBS care, with the percent of long-term care spending dedicated to HCBS having increased from 30.1% in fiscal 2020 to 37.5% in fiscal 2021. This measure is heavily influenced by the COVID-19 pandemic as nursing home utilization declined substantially but is not only reflective of that decline. In fiscal 2021, nursing home expenditures fell by 9.8%; however, HCBS spending increased by 25.9%.

Exhibit 2
Delivery of Long-term Care Services in Medicaid
Fiscal 2005-2021
($ in Millions)

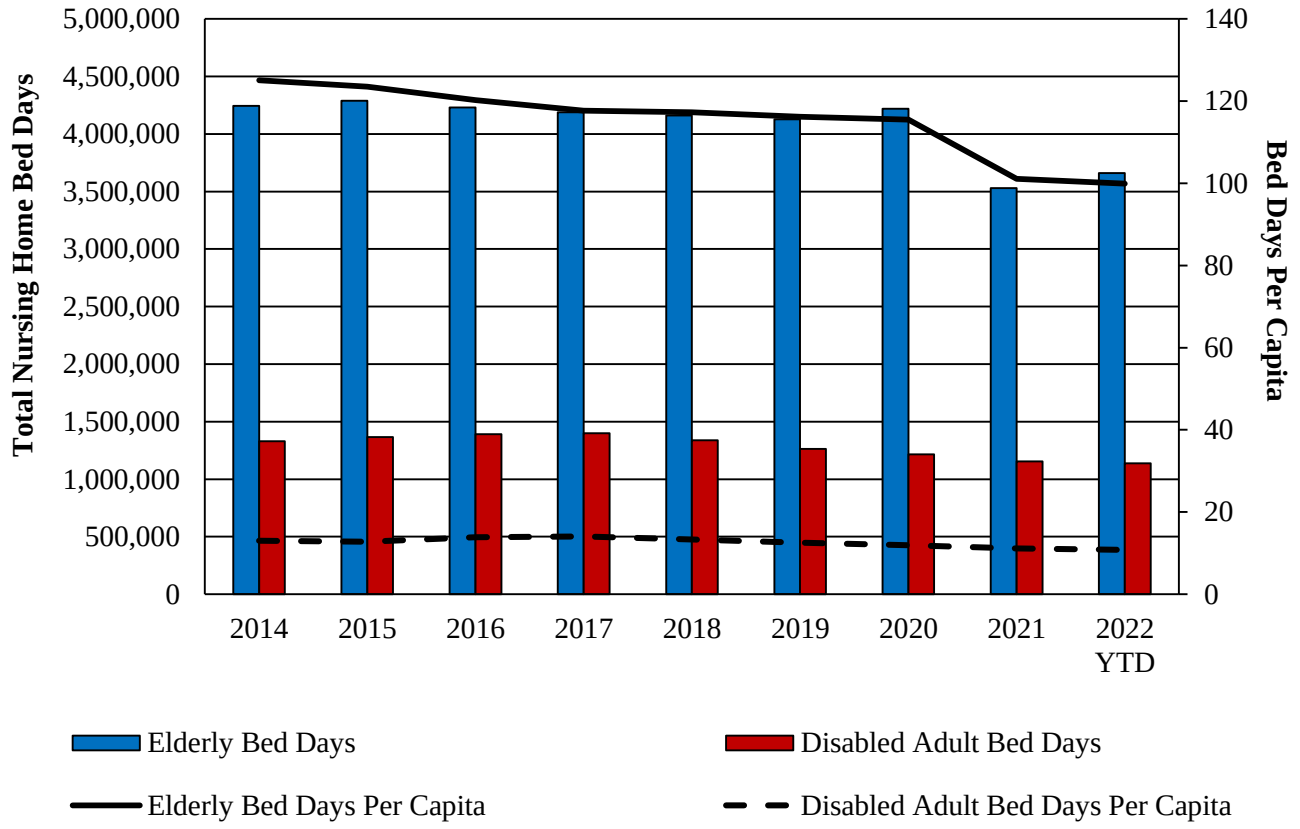


HCBS: home- and community-based services

Source: Maryland Department of Health; Department of Legislative Services

Exhibit 3 details trends in nursing home utilization (shown as bed days) among the two largest Medicaid user groups of nursing home care: the elderly; and disabled adults. Combined, these two groups used 99.6% of Medicaid-funded nursing home bed days in fiscal 2021. Many elderly enrollees access the Medicaid program by spending-down income once they enter nursing home care. Trends in the use of nursing homes by Medicaid recipients prior to fiscal 2021 mirrored the State's rebalancing efforts to reduce institutional care, showing a gradual decline in both total nursing home bed days and bed days per capita.

Exhibit 3
Nursing Home Utilization among Elderly and Disabled Adults
Fiscal 2014-2022 YTD



YTD: year to date through January 2022 annualized for comparison to prior years

Source: Maryland Department of Health; Department of Legislative Services

The sharp decline in fiscal 2021 trend reflects the impact of COVID-19 on elderly enrollment and utilization. From fiscal 2020 to 2021, average monthly elderly enrollment fell by 1,615 individuals, or 4.4%, and elderly bed days fell at a faster pace of 690,516 days, or 16%. This is likely related to the prevalence of COVID-19 deaths among nursing home residents reducing Medicaid enrollment among the elderly and causing lower demand for nursing home services.

Although nursing home utilization among the elderly increased slightly from 3.53 million in fiscal 2021 to 3.66 million in fiscal 2022 through January 2022 (a 3.8% increase), this remains far below the 4.2 million bed days recorded in fiscal 2020. A partial return to prepandemic nursing home utilization would be expected as individuals who delayed entering a nursing home during the height of the pandemic begin services and the State's elderly population increases overall. However, it is too

early to know the long-term impacts of the COVID-19 pandemic on long-term care services, including the extent to which nursing home enrollment and utilization have been rebased in the long run and whether recent efforts to expand HCBS availability will effectively rebalance long-term care services to community-based settings at a faster rate.

Fiscal 2021

Fiscal 2021 Accrual

At the end of each fiscal year, Medicaid accrues unspent funds to pay for Medicaid bills received in the following fiscal year but are charged back to the prior year. That accrual can also be used to cover other Medicaid-related expenses as needed. Funding that is not used should be reverted to the General Fund, while deficits usually result in deficiency appropriations. Based on data through September 2021, the Department of Legislative Services (DLS) estimates that the fiscal 2021 accrual for traditional Medicaid will have a surplus of at least $4 million in general funds. DLS expects the fiscal 2021 MCHP accrual to be just enough to cover costs. The fiscal 2023 budget does not include any adjustments or deficiencies recognizing any surpluses or deficits in the Medicaid or MCHP accrual.

Targeted Reversion Related to Fiscal 2021 Enhanced Federal Claiming

The fiscal 2023 budget plan assumes a reversion in fiscal 2022 in Medicaid of $13.1 million to reflect additional savings from the enhanced Federal Medical Assistance Percentage (FMAP) authorized during the national COVID-19 PHE. Funding is available in fiscal 2022 because MDH completed fiscal 2021 closeout before all claims in that year were finalized, and the department later reported $10.4 million more in enhanced matching funds than was initially reported. The remaining $2.7 million to be reverted adjusts projected enhanced claiming during the first two quarters of fiscal 2022 based on higher than anticipated fiscal 2021 actual claims.

Fiscal 2022

Proposed Deficiency

As shown in **Exhibit 4**, the fiscal 2023 budget includes proposed deficiencies and a planned reversion adding a net $72.1 million to the fiscal 2022 appropriation. The general fund appropriation decreases by $158.0 million, mainly due to enhanced federal matching funds creating equivalent general fund savings that are partially offset by expenditures covering increased enrollment and utilization projections.

Exhibit 4
Proposed Fiscal 2022 Deficiencies under Medicaid
($ in Millions)

	General Fund	Special Fund	Federal Fund	Total
Enrollment and Utilization Adjustments for Traditional Medicaid and ACA Expansion Populations	$54.4	-$4.5	-$47.2	$5.3
Enrollment and Utilization Adjustments for MCHP Enrollees and Reduction of Premium Collections, which Are Frozen during the COVID-19 PHE	13.1	-3.9	14.8	24.0
Managed Care Organization Vaccine Incentive Program	7.5		7.5	15.0
Shortfall under the LTSS Tracking System Major Information Technology Project (Discussed in **Appendix 3**)	3.1			3.1
Overtime Expenses under the Office of Enterprise Technology, Benefits Management, and Eligibility Services	0.0			0.0*
eFMAP under MCHP to Recognize the National COVID-19 PHE Extension through the Third Quarter of Fiscal 2022	-6.4		6.4	0.0
eFMAP under Medicaid to Recognize the National COVID-19 PHE Extension through the Third Quarter of Fiscal 2022	-107.5		107.5	0.0
HCBS Provider Rate Increases under Medicaid Using 10% eFMAP Authorized in the ARPA			37.4	37.4
HCBS Provider Rate Increases under MCHP Using 10% eFMAP Authorized in the ARPA			0.4	0.4
Subtotal	***-$35.7***	***-$8.4***	***$126.8***	***$85.2***
Deficiency Appropriations Included in Supplemental Budget No. 1				
eFMAP under Medicaid to Recognize the National COVID-19 PHE Extension through the Fourth Quarter of Fiscal 2022	-$105.1		$105.1	$0.0
eFMAP under MCHP to Recognize the National COVID-19 PHE Extension Through the Fourth Quarter of Fiscal 2022	-4.1		4.1	$0.0
Subtotal	***-$109.2***		***$109.2***	***$0.0***

	General Fund	Special Fund	Federal Fund	Total
Targeted Reversion				
Additional 6.2% Enhanced Federal Matching Funds Claimed in Fiscal 2021 and Projected Additional Federal Matching Funds in the First Two Quarters of Fiscal 2022	-$13.1			-$13.1
Total Fiscal 2022 Adjustments	**-$158.0**	**-$8.4**	**$235.9**	**$72.1**

ACA: Affordable Care Act
ARPA: American Rescue Plan Act
eFMAP: Enhanced Federal Medical Assistance Percentage
FMAP: Federal Medical Assistance Percentage
HCBS: home- and community-based services
LTSS: Long Term Services and Supports
MCHP: Maryland Children's Health Program
PHE: public health emergency

* Overtime expenses account for $46,273 in additional general fund spending in fiscal 2022.

Source: Department of Budget and Management

Fiscal 2022 COVID-19-related Aid Provided through Medicaid

Efforts to Increase Vaccination Rates among Medicaid Recipients

Overall COVID-19 vaccination rates among Medicaid beneficiaries have lagged compared to the rest of Maryland residents. During the Senate Vaccine Oversight Workgroup meeting held on November 15, 2021, the Secretary of Health, Dennis R. Schrader, indicated that more than two-thirds of unvaccinated Marylanders, or about 500,000 individuals, were Medicaid recipients. The Secretary also reported that only 49.6% of eligible Medicaid beneficiaries had received at least one dose compared to over 72% of Marylanders who were eligible for a vaccine having received at least one dose at that time.

Of the 1.6 million Marylanders enrolled in the Medicaid program (about 25% of the State's population), just under 1.5 million participate in the HealthChoice program and enroll with an MCO. A proposed deficiency appropriation of $15 million supports the new MCO Vaccine Incentive Program, which lasts from December 10, 2021, through March 31, 2022. Under the program, MDH established performance thresholds for increases in the rate of fully vaccinated individuals ages 12 and up. MCOs are able to determine how to reach the performance thresholds, and the department will reimburse MCOs per vaccinated individual once an MCO has reached a certain number of vaccinations set by MDH. In fiscal 2022, the program is not focused on vaccinating younger children or encouraging booster doses. However, the fiscal 2023 allowance also includes $5 million for this program, suggesting that MDH could prioritize other populations or metrics for promoting COVID-19 vaccines in the future.

One method Maryland's MCOs are implementing to encourage COVID-19 vaccinations among Medicaid recipients is a gift card program. Through this program, MCOs are distributing $100 gift cards to Medicaid recipients. MDH is not administering this program but is supporting it by marketing it on the department's website and providing outreach through the State call center. To be eligible for a gift card, Medicaid recipients must be:

- enrolled in the HealthChoice Program;
- 12 years old or older; and
- fully vaccinated between December 15, 2021, and March 31, 2022.

At the federal level, the American Rescue Plan Act (ARPA) aimed to improve COVID-19 vaccination rates among Medicaid recipients by requiring that State Medicaid programs cover all costs associated with COVID-19 vaccines and vaccine administration without cost sharing and by providing a temporary 100% FMAP for expenditures on vaccines and vaccine administration. The temporary 100% FMAP for these vaccine and vaccine administration costs remains in effect from April 1, 2021, through a year after the end of the national COVID-19 PHE. A December 2, 2021 Centers for Medicare and Medicaid Services (CMS) press release further specified that states must cover COVID-19 vaccine counseling visits for children and youth without cost sharing by considering these costs as part of vaccination administration, thereby making these costs eligible for the 100% FMAP as well.

In *Strategies to Increase COVID-19 Vaccination Rates in Medicaid Enrollees: Considerations for State Leaders*, published on December 3, 2021, by the National Academy of State Health Policy and Duke-Margolis Center for Health Policy, the following actions were identified as ways to improve vaccination rates among people covered by Medicaid:

- use data to monitor progress, identify disparities, and facilitate outreach;
- incentivize and support provider vaccination efforts;
- incentivize Medicaid plans to reach vaccination targets;
- identify opportunities to reduce barriers to vaccination; and
- provide technical assistance and communication resources to providers.

Aside from establishing performance benchmarks and providing reimbursements through the MCO Vaccine Incentive Program, MDH should discuss whether it is implementing the strategies listed above to encourage Medicaid recipients to get the COVID-19 vaccine and provide the vaccination targets set for MCOs under the incentive program. The department should also provide:

- **the latest data available for vaccination rates among all Medicaid recipients statewide;**

- **vaccination rates among HealthChoice participants by MCO, including how that data compares to MDH's performance thresholds that it set under the MCO Vaccine Incentive program; and**

- **the latest estimates for fiscal 2021 and 2022 year-to-date federal funding that will be claimed through the 100% FMAP for COVID-19 vaccine costs, including whether these costs are recognized in the fiscal 2023 budget plan.**

Enhanced Federal Matching Funds Extended through the End of Fiscal 2022

The Families First Coronavirus Response Act (FFCRA) provided a 6.2 percentage point increase on the State's FMAP for qualifying Medicaid expenses and a 4.34 percentage point increase to the Enhanced FMAP (eFMAP) for MCHP spending during a national PHE declared by the Secretary of the U.S. Department of Health and Human Services. States are eligible for the 6.2%eFMAP through the last day of the quarter in which the national COVID-19 PHE ends. On January 14, 2022, the Secretary of Health and Human Services, Xavier Becerra, extended the PHE by 90 days to April 15, 2022, thereby extending the FFCRA enhanced FMAP on qualifying Medicaid spending through the end of fiscal 2022. As a condition of receiving the eFMAP, State Medicaid programs must pause eligibility redeterminations and cannot disenroll people from the program, among other conditions.

As enacted, the fiscal 2022 budget accounted only for general fund savings resulting from enhanced matching funds through the end of calendar 2022. Over the course of this fiscal year, a variety of budget actions reflect subsequent PHE extensions and amendments to the estimated FMAP (across Medicaid and MCHP combined):

- a targeted reversion in fiscal 2022 recognizes $13.1 million in additional general fund savings due to higher than anticipated fiscal 2021 eFMAP claiming;

- a fiscal 2022 budget amendment signed by Governor Hogan on January 25, 2022, appropriated $238.3 million in federal funds that will be received for the first two quarters of fiscal 2022;

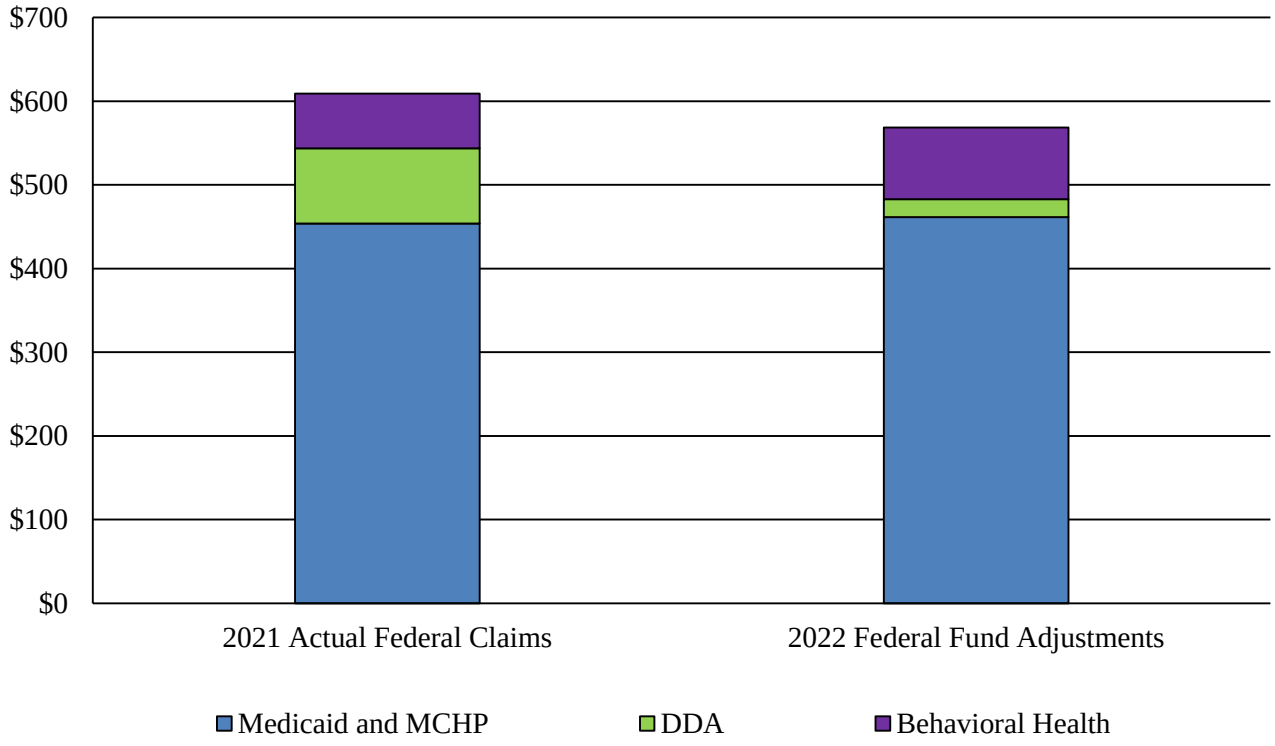
- as introduced, the fiscal 2023 budget plan included a proposed deficiency recognizing a fund swap of $113.9 million in general funds for enhanced federal matching funds to reflect the extension through the third quarter; and

- Supplemental Budget No. 1 to the fiscal 2023 budget plan provides another proposed deficiency appropriation swapping $109.2 million in general funds for federal funds to account for the latest PHE extension through the fourth quarter of fiscal 2022.

As shown in **Exhibit 5**, Maryland claimed $609.1 million in federal aid through the eFMAP on actual fiscal 2021 expenditures across Medicaid, BHA, and the Developmental Disabilities Administration (DDA), as authorized in the FFCRA. When including BHA and DDA, the budget adjustments outlined above have recognized a total of $568.5 million in estimated federal fund claiming

attributed to the COVID-19 eFMAP in fiscal 2022. DDA shows the smallest adjustment with only $21.5 million in additional federal fund claims because the fiscal 2022 federal fund appropriation has not been specifically adjusted to account for enhanced claims for three quarters of eFMAP. Additional discussion of eFMAP in DDA may be found within that analysis.

Exhibit 5
COVID-19 Enhanced Federal Matching Funds on Departmentwide Medicaid Expenses
Fiscal 2021-2022 Estimate
($ in Millions)



DDA: Developmental Disabilities Administration
MCHP: Maryland Children's Health Program

Note: Fiscal 2022 adjustments include funds added by budget amendment and proposed deficiency appropriations (including those appropriated through Supplemental Budget No. 1). Federal funds claimed through the Enhanced Federal Medical Assistance Percentage authorized through the national declaration of a COVID-19 public health emergency create largely equivalent general fund savings that have been recognized through negative deficiency appropriations and planned reversions in fiscal 2022.

Source: Department of Budget and Management; Maryland Department of Health; Department of Legislative Services

eFMAP for HCBS

A provision in the ARPA supports HCBS expansion efforts by authorizing a 10 percentage point increase to the FMAP on qualifying HCBS expenses from April 1, 2021, through March 31, 2022. CMS issued guidance in May 2021 requiring that all federal funds attributable to the 10% eFMAP be reinvested to enhance, expand, or strengthen HCBS under the Medicaid program by March 31, 2024. Additionally, states must use the enhanced federal fund claims to supplement, not supplant, existing State-funded HCBS spending.

Language in the fiscal 2022 Budget Bill (Chapter 357 of 2021) required that at least 75% of the eFMAP funding be used on a one-time provider rate increase. For HCBS providers under Medicaid, this translated to a 5.2% rate increase that took effect November 1, 2021, and will remain in place through March 31, 2024. Over that period, MDH estimates that it will spend $96.3 million on the provider rate increases.

There are two separate actions that appropriate federal funds for the HCBS rate increase under Medicaid and MCHP in fiscal 2022.

- A fiscal 2022 budget amendment signed by Governor Hogan on January 25, 2022, provided $78.4 million in federal funds to reflect the fiscal 2022 spending for the 5.2% HCBS rate increase under Medicaid.

- Subsequently, two proposed fiscal 2022 deficiency appropriations also provide a combined $37.8 million in federal funds across Medicaid and MCHP for the HCBS rate increase.

DLS recommends deleting the proposed fiscal 2022 deficiencies under Medicaid and MCHP for the 5.2% HCBS rate increase as funds were already appropriated through an approved budget amendment.

MDH initiated a request for public comment, that was open from October 12, 2021, to November 15, 2021, to gain stakeholder input on the use of the remaining 25% of funding (estimated at $32.1 million). The department received 30 comments from 23 individuals through this process, and the most common suggestions were increasing frontline workers' wages and benefits and shortening current waitlists for Medicaid HCBS programs.

The department is still determining how it will use the remaining federal funds, but MDH has notified stakeholders that filling HCBS slots is not an allowable use under the ARPA while Maryland has not filled all of its approved waiver slots. For example, Medicaid has 6,348 authorized slots under the Community Options Waiver in fiscal 2022. However, only 4,456 slots were filled through December 2021, preventing MDH from using HCBS eFMAP funding to enroll more individuals in the waiver program from the registry. As of November 5, 2021, there were over 21,000 individuals on the Community Options Waiver registry.

Aside from the HCBS eFMAP, the fiscal 2023 allowance includes $12.6 million ($5.6 million in general funds and $7.1 million in federal funds) to fill 400 slots in the program, and MDH plans to

fill 6 vacant positions specifically to aid the program in filling slots efficiently. Further discussion of the Community Options Waiver Program can be found in the MDH Overview analysis. **Considering the additional $12.6 million and personnel support for the Community Options Waiver Program, which is budgeted under the CFC program, DLS recommends adopting narrative requesting that MDH submit quarterly reports on Community Options Waiver and CFC program financial and registry data.**

Even after backing out the double-budgeted funds for the 5.2% HCBS rate increase, the fiscal 2022 working appropriation has $78.4 million in federal funds budgeted using funds attributed to the enhanced HCBS FMAP. This amount makes up a large share (81.4%) of the estimated $96.3 million that will be spent on the 5.2% HCBS rate increase discussed in the spending plan submitted to CMS. It is not clear whether this amount of federal funds would actually be spent in fiscal 2022 considering the rate increase took effect mid-year.

MDH should:

- **clarify its spending plan for the 5.2% HCBS rate increase by fiscal year, including the funding levels currently reflected in the fiscal 2022 working appropriation and fiscal 2023 allowance; and**

- **provide an update on whether any decisions have been made on the use of the remaining 25% of funds attributable to the HCBS eFMAP and a timeline by fiscal year for spending these funds**

DLS recommends adding language restricting funds for administrative purposes under the Office of the Deputy Secretary for Health Care Financing until MDH submits a report on accounting for HCBS waiver expansion spending.

ARPA State Fiscal Relief Funding for Nursing Homes and AMDCs

In a fiscal 2022 budget amendment signed by Governor Hogan on January 31, 2022, a total of $40 million from the ARPA State Fiscal Relief Fund was appropriated to Medicaid for staffing resources and COVID-19 testing, treatments, and vaccines at nursing homes ($25 million) and for grants to support increased operating costs at AMDC facilities ($15 million). Due to the timing of the amendment receiving approval, this funding is not yet included in the fiscal 2022 working appropriation. As of January 12, 2022, MDH was still in the process of developing a grant application template for nursing homes to apply for funding.

A notice on the MDH website provides some detail related to the AMDC operating grant opportunity, including the requirement that facilities must have reopened or plan to reopen within the next three months. Letters of intent and eligibility were due by February 11, 2022, and grant awards are being allocated to cover operating costs incurred between February 15, 2022, and the end of calendar 2022. MDH previously indicated that grant awards would be:

- distributed beginning in early February;
- based on a certain dollar amount per slot licensed with the Office of Health Care Quality; and
- provided to eligible AMDC facilities that do not serve any Medicaid recipients.

In budget hearing testimony for the MDH Administration analysis, MDH reported issues with processing invoices and disbursing grant awards in a timely manner due to limited personnel, higher volume of invoices due to the COVID-19 pandemic aid, and issues related to the ransomware attack. **MDH should provide an update on how much of the $15 million in operating grants has been distributed, the status of any delays or processing difficulties slowing the disbursement of funds, and any solutions or strategies that have been implemented to correct invoice processing and grant management issues.**

The $15 million in grant funding is in addition to an administrative per diem rate that has been used throughout the COVID-19 PHE to support AMDC facilities as they faced closures and increased operating costs upon reopening. MDH has been winding down this per diem rate from around 80% to 85% of the standard in-person per diem rate at the start of the pandemic to 25% at the beginning of calendar 2022. The surge related to the Omicron variant led MDH to apply to CMS for flexibility to increase the rate up to 50% as needed through the end of the national PHE, but this has not yet been approved or put into effect.

MCO Risk Corridor Agreements and Potential for State Recoveries

The COVID-19 pandemic led to lower health care service utilization in calendar 2020, causing MCOs to spend less relative to their capitated payments. Medicaid traditionally relies on the Medical Loss Ratio (MLR) requirement that 85% of capitated payments are spent on qualifying medical expenses to recoup underspending. Given the uncertainty around service utilization trends throughout the pandemic, CMS allowed states to retroactively enter two-sided risk corridor arrangements with MCOs so that states and MCOs would share in both savings and losses. MDH has incorporated risk corridor arrangements into MCOs' annual contracts in calendar 2020, 2021, and 2022. One exception is that Kaiser Permanente was excluded from the risk corridor arrangement in both years (as they are in regular rate-setting) due to its significantly higher operating costs and disproportionate risk of losses relative to other MCOs.

The risk corridor in calendar 2020 was based on each individual MCO's experience, with MCOs falling into a band based on MLR that puts them in a specific corridor. In a response to narrative in the 2021 JCR dated July 1, 2021, MDH outlined the lower bands that would provide the State with

additional savings, a neutral range of MLR between 88.2% and 92.2% that would not trigger a risk corridor adjustment, and the higher bands that would require the State and federal government to help cover 50% or 75% of MCO losses. Bands that provide the State with savings are shown in **Exhibit 6**, along with the preliminary results showing that five MCOs reported low enough MLRs to fall into these corridors. Under the risk corridor agreement, these MCOs must share 50% or 75% of their savings (shown as accruals) with MDH and the federal government. The JCR report specified that this data was still preliminary, and MDH has since indicated that the final settled amount for calendar 2020 will be known when MCOs' reviewed financial statements for calendar 2020 are available in May 2022.

Exhibit 6
Calendar 2020 Preliminary Risk Corridor Savings
($ in Millions)

MLR Corridor Resulting in Additional Savings for MDH	State/Federal Government Share of Gain	MCO Share of Gain	Preliminary MCOs Shared Savings	Reported Accruals
Corridor C+: MLR of Less Than 86.2%	75%	25%	Aetna, Amerigroup, CareFirst, UnitedHealthcare	-$93.0
Corridor B+: MLR between 86.2% and 88.2%	50%	50%	Priority Partners	-8.5
			Preliminary Estimated Total State/Federal Recovery	**-$101.5**

MCO: managed care organization
MDH: Maryland Department of Health
MLR: medical loss ratio

Note: Accruals were reported in different periods based on MCO but generally were reported as of March 31, 2021, or April 30, 2021.

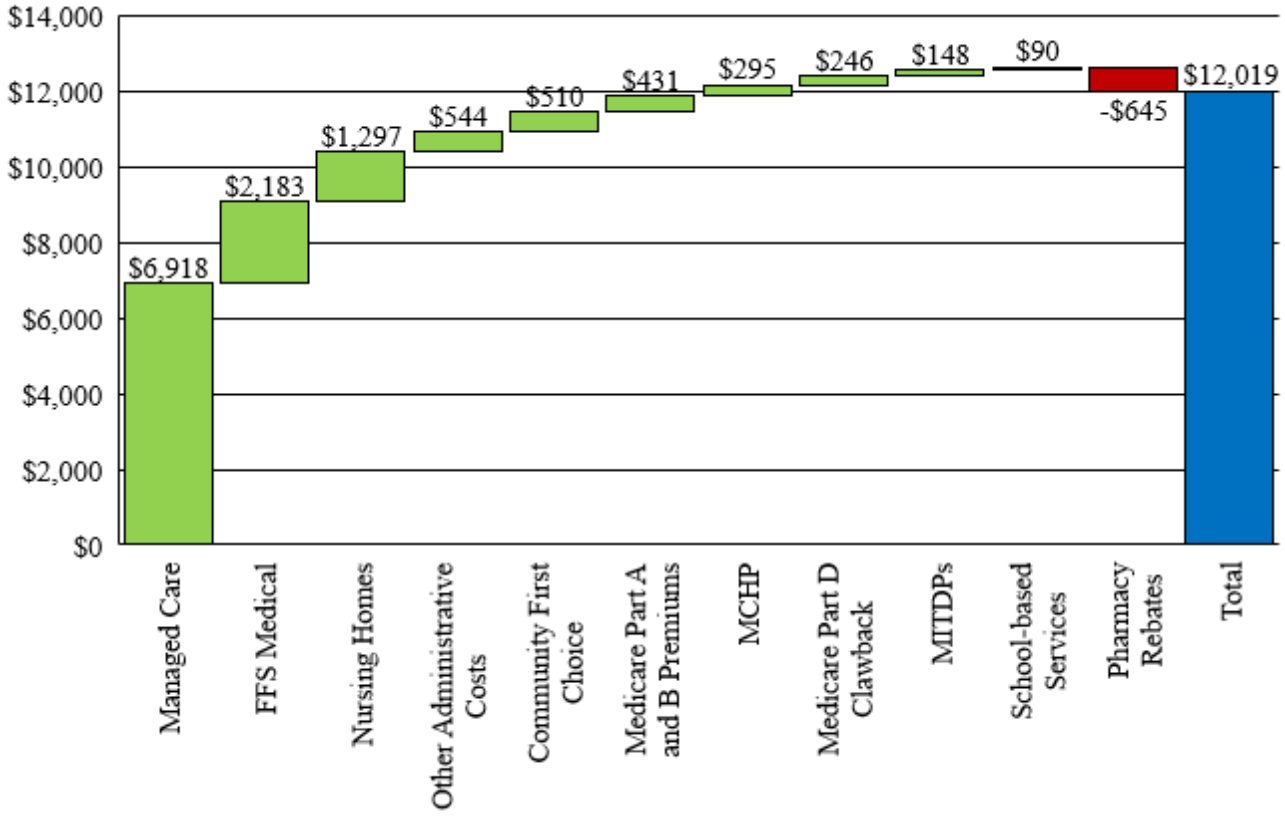
Source: Maryland Department of Health; Department of Legislative Services

Based on the preliminary results shown, MDH would receive a portion of the $101.5 million in estimated total recovery after the appropriate matching amount of savings is split with the federal government. DLS projects that Maryland would receive about $35 million of this estimated recovery based on federal fund participation across the Medicaid program. The fiscal 2022 working appropriation and fiscal 2023 allowance do not account for any calendar 2020 cost recoveries. Although MDH entered risk corridor agreements in calendar 2021 and 2022 as well, the methodology is slightly different as the agreements are based on programwide experience (with Kaiser Permanente still excluded). As of late January 2022, MDH estimated that the calendar 2021 risk corridor would not be triggered and reported that insufficient data was available to provide an estimate for calendar 2022. **DLS recommends adopting committee narrative that requests a report on MCO risk corridor settlements across calendar 2020 and 2021.**

Fiscal 2023 Overview of Agency Spending

Exhibit 7 presents MCPA's fiscal 2023 allowance, totaling $12.0 billion, by use of funds. Most of the funding ($6.9 billion, or 57.6%) supports health care services for traditional Medicaid enrollees participating in the Medicaid HealthChoice Program, referred to as Managed Care in the exhibit. Additionally, $3.5 million covers FFS medical costs, including dental coverage for children enrolled in Medicaid and adults in certain eligibility groups and nursing home costs. The CFC Program makes up an increasing share of the budget with $510 million, or 4.2%, supporting long-term care spending that has been gradually consolidated and expanded under CFC. Finally, the fiscal 2023 allowance includes $645 million in estimated pharmacy rebates partially offsetting Medicaid expenditures.

Exhibit 7
Overview of Agency Spending
Fiscal 2023 Allowance
($ in Millions)



FFS: fee-for-service
MCHP: Maryland Children's Health Program
MITDP: major information technology development project

Source: Maryland Department of Health; Department of Budget and Management; Department of Legislative Services

Proposed Budget Change

As shown in **Exhibit 8**, the fiscal 2023 allowance shows modest growth in total funds, increasing by $218.3 million (1.8%) over the fiscal 2022 working appropriation. Net growth is largely attributed to provider rate increases, which are partially offset by declining enrollment causing reduced spending. However, the change in State funds is much more significant as the budget grows by $645.0 million in general funds (19.5%). General fund expenditures increase in the fiscal 2023 allowance mainly to backfill eFMAP support temporarily provided during the COVID-19 national PHE.

Exhibit 8
Proposed Budget
MDH – Medical Care Programs Administration
($ in Thousands)

How Much It Grows:	General Fund	Special Fund	Federal Fund	Reimb. Fund	Total
Fiscal 2021 Actual	$2,604,899	$1,020,353	$7,089,095	$93,698	$10,808,044
Fiscal 2022 Working Appropriation	3,300,468	719,045	7,708,427	72,296	11,800,237
Fiscal 2023 Allowance	3,945,440	755,056	7,235,725	82,309	12,018,530
Fiscal 2022-2023 Amount Change	$644,972	$36,011	-$472,703	$10,013	$218,293
Fiscal 2022-2023 Percent Change	19.5%	5.0%	-6.1%	13.8%	1.8%

Where It Goes:	Change
Personnel Expenses	
Turnover expectancy (decreasing from 8.5% in fiscal 2022 to 6.9% in fiscal 2023)	755
Regular earnings associated with 5.0 positions transferred as part of the Maryland Primary Care Program Management Office reorganization	601
Accrued leave payout	272
Additional assistance in the form of leave payouts and other salary adjustments, increased based on recent actual spending	260
Employee and retiree health insurance	216
Overtime expenses	191
Retirement contributions	80
Other regular earnings, including a net reduction of approximately $515,606 for other position transfers	-624
Other fringe benefit adjustments	-10

Where It Goes:	**Change**
Provider Reimbursements and Contracts	
Provider rate increases (see **Exhibit 10** for more detail)	332,996
Community First Choice (excluding rate increase), including $12.6 million to expand the Community Options Waiver by 400 slots	100,497
Decline in pharmacy rebates	48,855
Medicare A and B premium assistance	40,030
First year of funding for the Population Health Incentive Program, which replaces the Value-based Purchasing Program (discussed in Issue 2)	35,000
Medicare Part D clawback payments	32,485
Maryland Quality Innovation Program providing payments to UMB physicians for investments and attainment of certain performance measures	22,299
Federally Qualified Health Center supplemental payments	6,575
Funding for the Employed Individuals with Disabilities Program, including $4.6 million to expand eligibility	5,810
Assistance in Community Integration Services Pilot	4,800
MMIS maintenance contracts and other administrative contracts	3,488
Graduate Medical Education payments	2,150
Health Home payments	-1,816
Reconciliation of grants awarded in a prior year	-1,986
Utilization reviews	-5,000
MCO Rural Access Incentive	-7,000
Health information technology payments (federal funds)	-9,350
Continuation of an MCO Vaccine Incentive program at a lower level	-10,000
Maryland Children's Health Program	-20,617
One-time 2% nursing home rate increase budgeted in fiscal 2022 (federal funds)	-26,000
Expenditures using 10% enhanced FMAP for HCBS authorized in ARPA (federal funds)	-35,679
Double budgeted federal funds added through a fiscal 2022 deficiency appropriation to recognize the enhanced FMAP for HCBS	-37,428
Enrollment and utilization	-314,820
Other Changes	
MMIS MITDP (see **Appendix 2** for more information)	34,488
Funding from the Regional Partnership Catalyst Grant Program for maternal and child health uses (special funds and federal funds)	16,000
Contract with CRISP to support health information exchange technology	12,005
Long Term Services and Supports Tracking System MITDP, after accounting for a fiscal 2022 deficiency appropriation (see Appendix 3 for more information)	6,448
Operational expenses for the Maryland Primary Care Program Management Office	2,026
Maternal Opioid Misuse Model cooperative agreement funds (federal funds)	519
Pharmacy services audits in response to a finding in an audit by Office of Legislative Audits	500

Where It Goes:	**Change**
Coverage 2.0 grant for developing a sustainable coverage model for National Diabetes Prevention Programs in Medicaid	250
Senior Prescription Drug Assistance Program (special funds)	151
Fund swap for the Home Visiting Services pilot, which will be supported with funds from the Regional Partnership Catalyst Grant Program (special and federal funds)	-5,400
End of a contract with Towson University to develop an electronic registration and attestation system	-21,600
Other operating expenses	5,876
Total	**$218,293**

ARPA: American Rescue Plan Act
FMAP: Federal Medical Assistance Percentage
HCBS: home- and community-based services
MCO: managed care organization
MDH: Maryland Department of Health
MITDP: major information technology development project
MMIS: Medicaid Management Information System
UMB: University of Maryland, Baltimore Campus

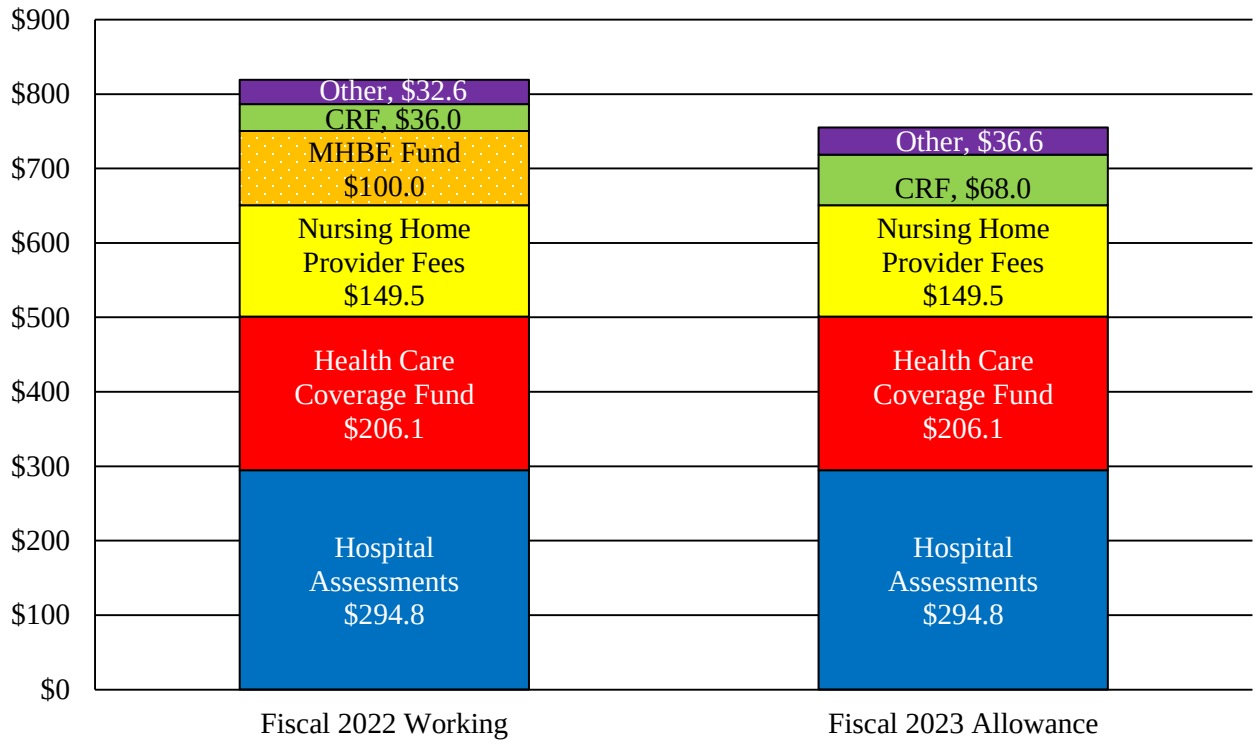
Note: The fiscal 2022 working appropriation includes funds added through proposed deficiencies, including those appropriated through Supplemental Budget No. 1, and targeted reversions. The fiscal 2022 working appropriation and fiscal 2023 allowance do not reflect funding for statewide personnel actions budgeted in the Department of Budget and Management, which includes cost-of-living adjustments, increments, bonuses, and annual salary review adjustments. Numbers may not sum to total due to rounding.

Special Fund Availability

The fiscal 2023 allowance currently reflects a $36.0 million increase in special fund availability over the fiscal 2022 working appropriation. However, a provision in the Budget Reconciliation and Financing Act (BRFA) of 2021 authorized the transfer of $100.0 million in reinsurance provider assessment revenue from the Maryland Health Benefit Exchange (MHBE) to Medicaid in fiscal 2021 and 2022 only. These funds have not yet been transferred to Medicaid in fiscal 2022. For purposes of examining special fund availability, the MHBE funds are accounted for as if the funds are included.

Exhibit 9 details a variety of special fund sources that support Medicaid expenditures in the fiscal 2022 working appropriation and fiscal 2023 allowance. Overall special fund availability decreases by $64.0 million in fiscal 2023, after adjusting for the available but not yet appropriated MHBE funds causing a $100.0 million decline in available special funds in fiscal 2023.

Exhibit 9
Special Fund Support for Medicaid
Fiscal 2022-2023
($ in Millions)



CRF: Cigarette Restitution Fund
MHBE: Maryland Health Benefit Exchange

Note: The fiscal 2022 working appropriation includes proposed deficiencies. A provision in the Budget Reconciliation and Financing Act of 2021 required the transfer of $100 million in health insurance provider fee assessments budgeted in the MHBE Fund to Medicaid in fiscal 2021 and 2022. At the time the fiscal 2023 budget was introduced, the funds had not yet been transferred to Medicaid. Still, this funding is shown in fiscal 2022.

Source: Governor's Fiscal 2023 Budget Books

The $100.0 million reduction in MHBE special funds in fiscal 2023 is partially offset by increases related to Cigarette Restitution Fund (CRF) spending under Medicaid. In fiscal 2023, CRF spending increases by $32.0 million to a total of $68 million. Section 7-317 of the State Finance and Procurement Article requires that at least 30% of the CRF appropriation in each fiscal year must be allocated to Medicaid. At $68.0 million, CRF expenditures under Medicaid surpass this mandated level, making up about 37% of planned expenditures from CRF. Further discussion of the CRF can be found in the MDH Overview analysis.

Provider Rates

The largest change in the Medicaid budget, an increase of $333.0 million between fiscal 2022 and 2023, is attributable to provider rate increases. **Exhibit 10** lists increases by service/provider type contributing to the overall increase. Mandated 4% rate increases for certain providers defined in Chapters 10 and 11 of 2019 are fully funded in the fiscal 2023 allowance. There are also discretionary enhancements to Medicaid rates, such as $68.5 million to raise physician evaluation and management fees to 100% of Medicare rates. Medicaid has typically tried to maintain these rates at a minimum 93% of Medicare rates in recent years.

Exhibit 10
Medicaid Provider Rate Changes and Rate Assumptions
Fiscal 2023
($ in Millions)

	Rate Change
Managed Care Organization Calendar 2022 (2.7%)	$140.6
Physician Evaluation and Management (Raising Rates to 100% of Medicare Rates)	68.5
Nursing Homes (Mandated 4%)	53.7
Dental Services	19.6
Inpatient and Outpatient Services (2.43%)	17.2
Community First Choice (Mandated 4%)	16.6
Medical Day Care (Mandated 4%)	5.4
Durable Medical Equipment (Restoring to 85% of Medicare Rates)	5.1
Private Duty Nursing (Mandated 4%)	4.6
Home- and Community-based Services (Mandated 4%)	1.0
Personal Care (Mandated 4%)	0.4
Rare and Expensive Case Management Services (Mandated 4%)	0.1
Total	**$333.0**

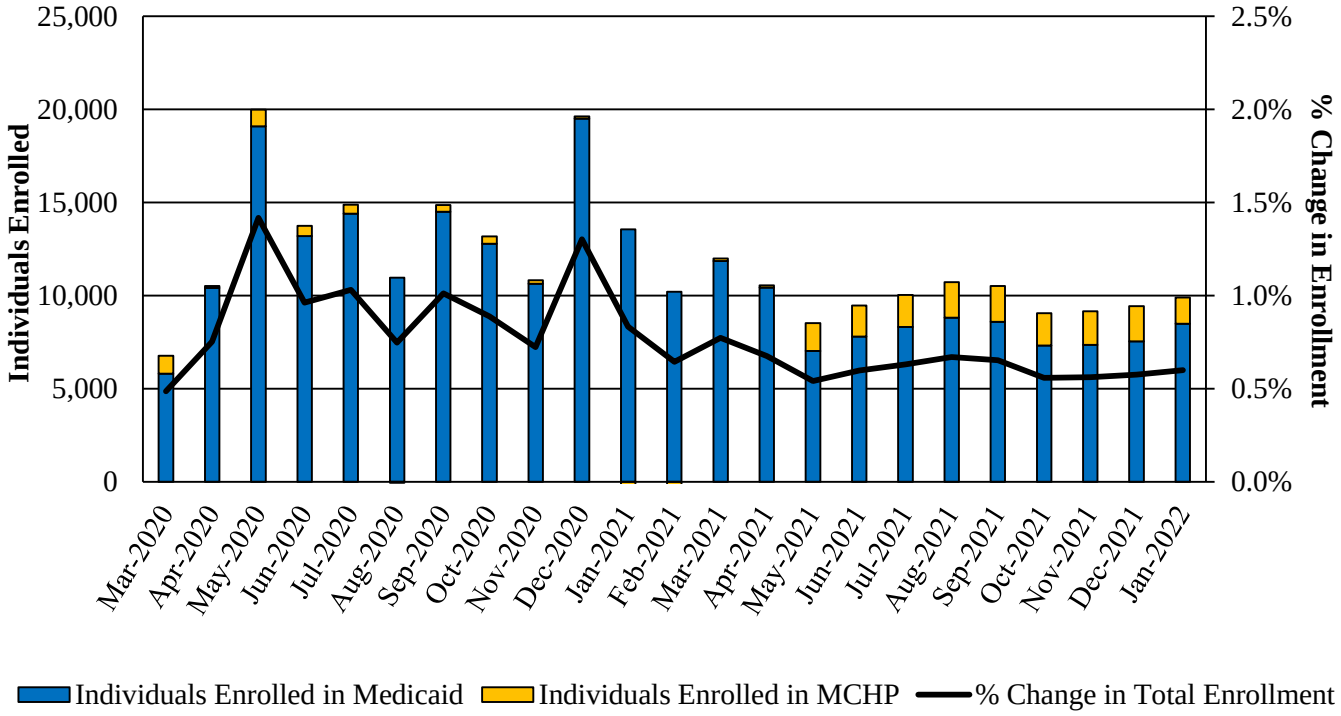
Source: Department of Budget and Management; Maryland Department of Health; Department of Legislative Services

Rates for dental services also increase by $19.6 million on a discretionary basis in fiscal 2023. At a Maryland Medicaid Advisory Committee meeting in January 2022, MDH indicated that the method for distributing the rate increase for dental services was not finalized. **The department should provide an update on how it plans to distribute the dental services rate increase, specifically discussing whether all dental services will receive a rate increase or if the funding will be targeted to certain services.**

Fiscal 2022 and 2023 Projected Enrollment

Following provider rate increases, the budgetary impact of enrollment and utilization projections is the next largest driver of budget change between fiscal 2022 and 2023. As shown in **Exhibit 11,** total month-over-month Medicaid enrollment change grew rapidly after the onset of the COVID-19 pandemic in March 2020, reporting an average of 11,623 new enrollees per month between March 2020 and January 2022.

Exhibit 11
Month-over-month Change in Medicaid and MCHP Enrollment
March 2020 to January 2022



MCHP: Maryland Children's Health Program

Source: Maryland Department of Health; Department of Legislative Services

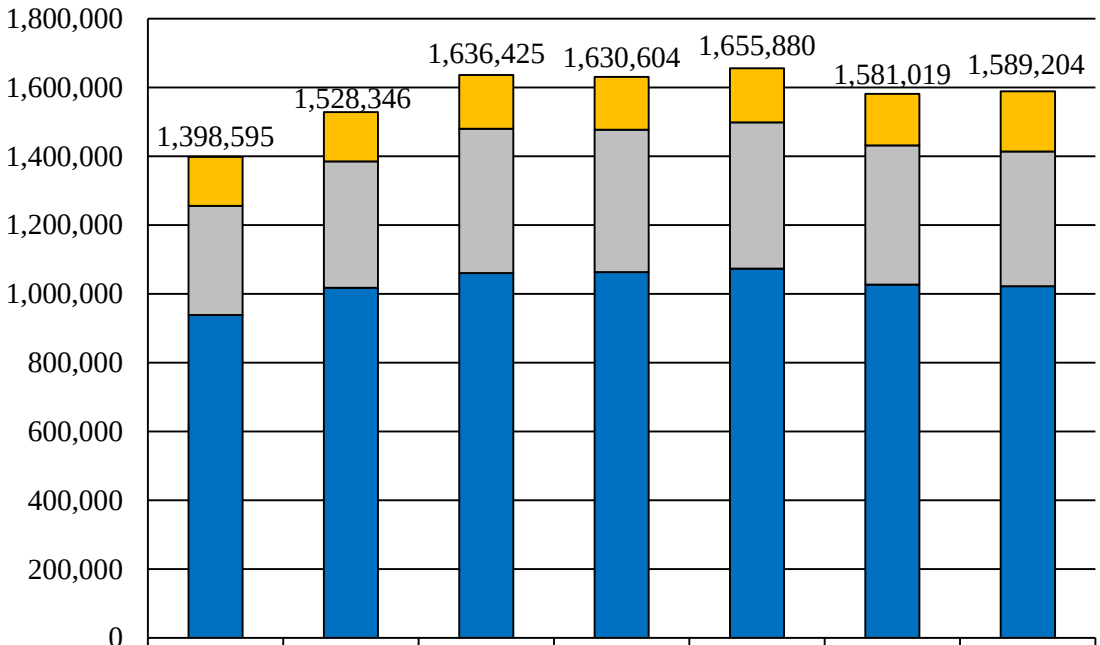
Month-over-month enrollment growth has leveled off slightly since May 2021 but remains elevated throughout fiscal 2022. This is mainly due to the requirement that State Medicaid programs suspend eligibility redeterminations and cease termination of coverage as a condition of receiving the FFCRA eFMAP during the COVID-19 PHE, although some of the continued growth could be related to lingering economic impacts of the pandemic on low-income Maryland residents.

Unlike other eligibility groups that saw larger growth in enrollment in calendar 2020, enrollment in MCHP has increased by over 1,000 new enrollees per month since May 2021. This represents a rapid change from the rest of the period when only 226 new enrollees on average were added each month from March 2020 to April 2021.

While MDH has not been terminating any individual's Medicaid coverage, the department has moved individuals between eligibility groups as applicable. Due to MCHP's higher income threshold set at 300% of FPL, it is probable that increased enrollment at least partially results from families' household income improving from traditional Medicaid into the MCHP category. This transition does not cause any change in benefits and allows the State to receive 65% federal matching funds for those individuals, rather than the typical 50% FMAP. Governor Hogan suspended MCHP premium payments required for families with incomes between 200% and 300% FPL during the COVID-19 PHE, further limiting the difference between eligibility groups, at least through the end of the COVID-19 PHE.

Due to multiple extensions of the COVID-19 PHE, and therefore extensions of the pause on disenrollment, fiscal 2022 year-to-date total Medicaid enrollment has risen substantially over recent actual average enrollment. As shown in **Exhibit 12**, the fiscal 2022 year-to-date average monthly enrollment increased by 232,009 enrollees (16.6%) and 102,258 enrollees (6.7%), compared to fiscal 2020 and 2021 actuals, respectively. When the fiscal 2023 budget plan was introduced, this freeze on eligibility redetermination was scheduled to end March 31, 2022. Therefore, enrollment would have been expected to begin decreasing across most, if not all, eligibility categories in the final quarter of fiscal 2022 as MDH resumed eligibility redetermination. This would have put a slight downward pressure on the average monthly enrollment in fiscal 2022.

Exhibit 12
Medicaid and MCHP Average Monthly Enrollment
Fiscal 2020-2023 DLS Estimate



	2020	2021	2022 Budget	2022 YTD	2022 Estimate	2023 Budget	2023 Estimate
MCHP	143,031	143,387	156,380	153,254	157,584	149,330	175,370
ACA Expansion	316,313	367,288	419,105	414,104	425,059	404,232	391,665
Traditional Medicaid	939,251	1,017,671	1,060,940	1,063,245	1,073,237	1,027,457	1,022,169

ACA: Affordable Care Act
DLS: Department of Legislative Services
MCHP: Maryland Children's Health Program
YTD: year-to-date

Source: Maryland Department of Health; Department of Budget and Management; Department of Legislative Services

A proposed fiscal 2022 deficiency appropriates a net increase of $5.3 million to the Medicaid budget and $24.0 million to the MCHP budget as a mid-year adjustment to offset increased enrollment compared to levels assumed in the fiscal 2022 legislative appropriation. This action also accounts for changes in utilization and provider rate assumptions. When this adjustment is taken into account, as shown in Exhibit 12, the revised enrollment in the fiscal 2022 working appropriation closely aligns with year-to-date enrollment through January 2022, showing a difference of only 5,821 more enrollees. DLS' fiscal 2022 enrollment forecast assumes approximately 25,000 more average monthly enrollees compared to the budget projection to account for the additional quarter that MDH will not disenroll Medicaid recipients from the program.

Exhibit 13 compares the Department of Budget and Management's (DBM) revised enrollment figures assumed in the fiscal 2022 budget and fiscal 2023 allowance to DLS' fiscal 2022 and 2023 enrollment forecast. In both models, fiscal 2023 total enrollment falls by at least 3% as the COVID-19 PHE is expected to end in fiscal 2022. This results in Medicaid enrollment decreasing as MDH resumes eligibility redeterminations and individuals found to be ineligible are disenrolled. Further, decreases are expected as the economy continues to recover from the pandemic. DBM's revised enrollment and utilization changes in the fiscal 2023 allowance translate to a net reduction of $230.4 million in Medicaid spending.

Exhibit 13
DLS and DBM Enrollment Forecasts
Fiscal 2022-2023

	2022		2023		% Change 2022-2023	
	Revised Budget	DLS Estimate	Allowance	DLS Estimate	DLS 2022 Estimate to Allowance	DLS 2022 Estimate to DLS 2023 Estimate
Traditional Medicaid	1,060,940	1,073,237	1,027,457	1,022,169	-4.27%	-4.76%
ACA Expansion	419,105	425,059	404,232	391,665	-4.90%	-7.86%
MCHP	156,380	157,584	149,330	175,370	-5.24%	11.29%
Total	**1,636,425**	**1,655,880**	**1,581,019**	**1,589,203**	**-4.52%**	**-4.03%**

ACA: Affordable Care Act
DBM: Department of Budget and Management
DLS: Department of Legislative Services
MCHP: Maryland Children's Health Program

Source: Department of Budget and Management; Department of Legislative Services

Despite coming to similar total enrollment projections, the difference in enrollment assumptions are more noticeable within eligibility categories. This is especially true in the MCHP eligibility category as DBM expects fiscal 2023 MCHP enrollment to decrease compared to fiscal 2022, while DLS expects MCHP enrollment to continue increasing. DLS' estimate for MCHP enrollment anticipates recent enrollment growth in that category specifically to continue even beyond the end of the COVID-19 national PHE, primarily as children no longer eligible for Medicaid remain eligible for MCHP with its higher income eligibility limits.

Enrollment Redetermination Process

The slight differences between DBM's and DLS' estimates for total enrollment in fiscal 2022 and 2023 are mainly attributable to the anticipated timing of when the COVID-19 PHE would end and eligibility redetermination resumes. At the time that the budget was formulated, the COVID-19 PHE was set to expire in mid-January 2022, in which case eligibility redeterminations would have resumed

on April 1, 2022. Since then, Secretary Becerra has extended the COVID-19 national PHE, thereby pushing the redetermination timeline out another three months to the start of fiscal 2023.

In August 2021, CMS issued guidance to state Medicaid programs on planning a return to normal operations and eligibility redeterminations. This guidance provided states with flexibility in addressing any backlogs but also allows states to work through backlogs over 12 months following the end of the COVID-19 PHE. One of the reasons for this decision was to avoid overloading any one month with more eligibility redeterminations than a Medicaid office could feasibly manage. This first year of redeterminations will effectively create a new annual redetermination schedule moving forward. States, however, can still determine their own redetermination timeline within 12 months after the COVID-19 PHE, so there will likely be a wide range in results across states that take an aggressive approach versus states that space out the process.

MDH has previously indicated that it plans to use the full 12 months after the COVID-19 PHE to complete its redetermination process and that its current personnel will be sufficient to work through backlogs. In the first six months, however, MDH plans to expedite redeterminations for certain individuals that are more likely to be ineligible for coverage. The department described certain factors that make this group (estimated at just under 50,000 people) more likely to not meet eligibility requirements anymore, such as reporting an increase in household income above the maximum threshold or an individual not meeting technical eligibility after aging out of Medicaid and into Medicare coverage during the COVID-19 PHE.

Once states start terminating coverage again, there is some concern that State agencies may disenroll individuals who are eligible for Medicaid and had some change in their mailing address or some other difficulty confirming their eligibility status. **MDH should discuss current outreach activities and planned outreach activities following the end of the COVID-19 PHE to inform Medicaid beneficiaries that redetermination and disenrollment will resume on July 1, 2022. DLS recommends that the committees add language restricting funds for the purpose of administration until MDH submits quarterly reports with data and status updates related to the redetermination process.**

Fiscal 2022 and 2023 General Fund Adequacy

Increased enrollment and utilization resulting from multiple extensions of the COVID-19 PHE and required freeze on eligibility redeterminations causes a slight increase in Medicaid and MCHP expenditures. However, the additional quarters of the FFCRA eFMAP providing over $100 million per quarter in federal aid and the potential for some share of State recoveries through the calendar 2020 risk corridor agreements with MCOs are more than enough to cover estimated fiscal 2022 costs.

In fiscal 2023, DLS enrollment projections are slightly higher than the enrollment level the budget is based on. However, the eligibility categories with the largest differences are children, who are relatively inexpensive to cover. DLS estimates that the fiscal 2023 allowance will also be sufficient to cover costs in traditional Medicaid though there could potentially be a slight deficit in MCHP.

Personnel Data

	FY 21 Actual	FY 22 Working	FY 23 Allowance	FY 22-23 Change
Regular Positions	608.90	615.00	611.00	-4.00
Contractual FTEs	71.98	111.41	114.83	3.42
Total Personnel	**680.88**	**726.41**	**725.83**	**-0.58**

Vacancy Data: Regular Positions

Turnover and Necessary Vacancies, Excluding New Positions	42.16	6.90%
Positions and Percentage Vacant as of 12/31/21	84.60	13.76%
Vacancies Above Turnover	42.44	

- The fiscal 2023 allowance reflects a net reduction of 4 regular positions under MCPA compared to the fiscal 2022 working appropriation. This is driven by:
  - 6 positions transferred from MCPA to the Office of the Chief Medical Examiner;
  - A net 3 positions transferred from MCPA to other MDH offices and divisions as part of the department's annual review process for realigning vacant positions; and
  - 5 positions transferred to MCPA as part of the Maryland Primary Care Program Management Office reorganization from MDH Public Health Services to the Office of the Deputy Secretary for Health Care Financing.
- Budgeted turnover in the fiscal 2023 allowance decreases by 1.55 percentage points, reducing the number of needed vacancies by 9.81, compared to fiscal 2022. Although this provides more funding for MDH to hire employees, the department has consistently had 15 or more vacancies above budgeted turnover at the end of each year since calendar 2018. As of December 31, 2021, there were 42.44 more vacancies than the new turnover expectancy. Further discussion of MDH's vacancies may be found in the MDH Overview analysis.

Issues

1. MDH Receives Federal Approval for Section 1115 HealthChoice Waiver Renewal

On June 30, 2021, MDH submitted a renewal application for the mandatory managed care program, Maryland HealthChoice, which is authorized through a Section 1115 Waiver that first took effect in 1997. The application was developed after MDH held virtual webinars to solicit stakeholder feedback and opened a 30-day public comment period on the planned programmatic changes. An MDH press release issued on January 6, 2022, announced CMS' approval of the five-year waiver renewal, effective January 1, 2022. **Exhibit 14** lists the new programs, programmatic changes, and existing pilot program extensions authorized in the renewal.

Exhibit 14
New and Existing Programs Affected or Extended through the Section 1115 Waiver Renewal

Existing Program/Service: Continue as Is	Existing Program/Service Continue with Modification	New Program/Service
Adult Dental Pilot Program	Assistance in Community Integration Services – ACIS Pilot	Emergency Triage, Treat and Transport Model – ET3
Breast and Cervical Cancer Program	Home Visiting Services – HVS Pilot	Expansion of Institutions of Mental Disease – IMD – for Severe Mental Illness
Collaborative Care Pilot Program	Residential Treatment for Substance Use Disorder	Maternal Opioid Misuse – MOM Model
HealthChoice Diabetes Prevention Program		
Hospital Presumptive Eligibility Process		
Increased Community Services		

Source: Maryland Department of Health, *Public Notice: Maryland's Section 1115 HealthChoice Demonstration Waiver Renewal*

New Programs or Services

With the formal acceptance by CMS of the waiver application, MDH can begin to implement several programs and services outlined in the application.

ET3 Model

The ET3 model is a voluntary, five-year payment model in Annapolis, Baltimore City, and Montgomery County for ambulance care teams to be reimbursed for ground transport to alternative destinations, such as an urgent care provider. The Maryland Institute for Emergency Medical Services Systems has previously discussed how this type of alternative destination reimbursement could improve overcrowding and lengthy wait times in the State's emergency departments.

Expansion of IMD Services for Adults with SMI

During the former HealthChoice waiver period, MDH could not claim federal matching funds for any services provided by IMDs to individuals between 22 to 64 years old. However, CMS allowed an exception to this rule to provide SUD treatment in nonpublic IMDs for individuals ages 21 through 64 with a primary SUD diagnosis and secondary mental health diagnosis. This exception is retained under the new waiver renewal, and the federal match is extended to IMD services for adults ages 22 to 64 with an SMI. The fiscal 2022 working appropriation and fiscal 2023 allowance include $30 million in general funds each year in BHA for IMD services that will now receive Medicaid reimbursement. This should generate at least $15 million in general fund savings under the new waiver renewal.

Language in Chapter 357 required MDH to submit a report addressing barriers to removing the CMS IMD designation for psychiatric hospitals, funding adequacy for IMDs, and steps taken by the department to ensure adequate funding. In the report submitted on July 30, 2021, MDH discussed how additional funding would become available for IMDs if CMS approved the HealthChoice 1115 waiver renewal application that requested further expanding coverage to all participants ages 21 to 64 with an SMI. As discussed, the waiver renewal was approved, and IMDs will now be able to be reimbursed for these costs through Medicaid.

MOM Model

The MOM Model is an existing pilot program in St. Mary's County aiming to address the opioid epidemic's impact on maternal health. The program aims to reduce the burden of neonatal abstinence syndrome by offering case management with somatic and behavioral care to pregnant people diagnosed with an opioid use disorder. Effective July 1, 2022, the program will begin a transition to statewide operation.

Existing Programs or Services Continued with Modification

Of the following programs and services, MDH began implementing the two pilot programs at the start of fiscal 2018 when the former application renewal period began.

Assistance in Community Integration Services Pilot

Under the statewide Assistance in Community Integration Services Pilot program, lead local government entities apply for federal matching funds to provide a set of HCBS, such as tenancy-based or housing case management, tenancy support services, and other services, to high-risk, high-utilizing Medicaid enrollees who are at risk of institutional placement or homelessness. Program participants must meet certain need-based criteria for health or housing. The new waiver renewal expands the existing approval from 600 slots to 900 slots, increasing fiscal 2023 spending on the program by $4.8 million.

Home Visiting Services Pilot

In the former waiver period, MDH implemented a pilot program for lead local government entities to receive federal matching funds for serving high-risk pregnant women and children up to age two through models for maternal health (Nurse Family Partnership and Healthy Families America). Specifically, under Health Families America, the new waiver period allows children up to age three to participate. In fiscal 2023, this program is supported with special funds transferred from the Health Services Cost Review Commission's Regional Partnership Catalyst Grant Program, as authorized in the BRFA of 2021. Further discussion of funding for maternal and child health programs using these grant funds can be found in the MDH Overview analysis.

Residential Treatment for SUD

MDH also received CMS approval to cover providers in contiguous states as well as providers in Maryland for certain levels of residential services (medically managed intensive inpatient services in IMDs).

2. VBP Program Transitions to Incentive Only Population Health Incentive Program

Medicaid invests significant effort in a variety of quality assurance efforts around the HealthChoice program, including:

- record reviews and network adequacy testing to monitor operations;
- survey collections to evaluate enrollee and provider satisfaction;
- HEDIS data collection, the VBP program, and performance improvement projects for quality measurement; and
- an annual technical report for general program management and oversight.

The most visible HealthChoice quality assurance program was VBP, which began in 1999. As a pay-for-performance effort under HealthChoice, VBP's goal was to improve MCO performance by providing monetary incentives and disincentives up to 1% of each MCO's total capitated payments based on performance in certain healthcare measures identified by MDH. In calendar 2020, the following nine measures were chosen for consideration in VBP to determine incentives and disincentives:

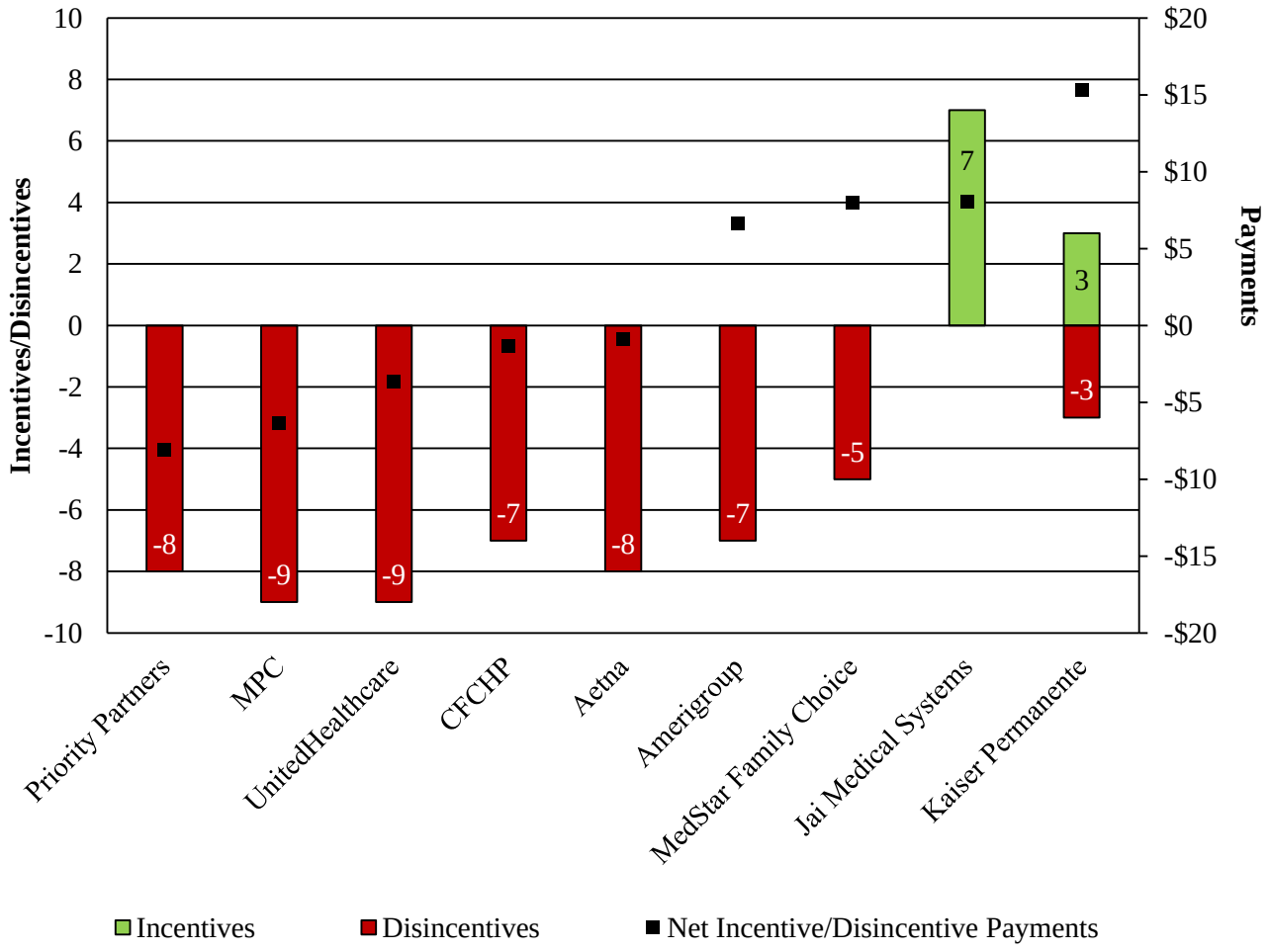
- adolescent well-care visits;
- ambulatory care visits for SSI adults;
- ambulatory care visits for SSI children;
- asthma medication ratios;
- breast cancer screening;
- comprehensive diabetes care (HbA1c control of less than 8.0%);
- controlling high blood pressure;
- lead screenings for children (ages 12 months to 23 months); and
- well-child visits for children (ages 0 months to 15 months)

Under VBP, MCOs with scores exceeding certain targets for each measure received an incentive payment, while MCOs with scores below the target were required to pay a penalty. There is also a midrange target for which an MCO receives no incentive payment but does not pay a penalty either. Similarly, plans that do not have a sufficient population for any particular measure cannot earn an incentive or be penalized. Incentive and penalty payments equal up to one-ninth of 1% of the total capitation paid to an MCO during the measurement year per measure with total penalty payments not to exceed 1% of the total capitation paid to a MCO during the measurement year. The penalty payments are used to fund the incentive payments.

If collected penalties exceeded incentive payments, the surplus was distributed in the form of a bonus to the four highest performing MCOs using normalized scores and relative enrollment. In recent years, this secondary distribution has resulted in the perverse result that an MCO with more disincentives than incentives on VBP targets can still benefit as one of the "top four" performers. Calendar 2020 results were no exception to this skewed distribution and even resulted in two MCOs receiving net incentive payments despite not meeting any incentive targets, as shown in **Exhibit 15**. MedStar Family Choice and Amerigroup did not achieve incentive targets for any of the nine measures and still received net payments of $8.0 million and $6.6 million, respectively, due to the secondary

distribution. Incentive outcomes for the VBP calendar 2020 results were worse across the board compared to the prior year. For example, five MCOs reached incentive targets in at least one measure in calendar 2019 versus only two MCOs in calendar 2020.

Exhibit 15
Results of Value-based Purchasing
Calendar 2020
($ in Millions)



CFCHP: CareFirst Community Health Plan
MPC: Maryland Physicians Care

Note: CFCHP acquired University of Maryland Health Partners (UMHP), therefore CFCHP presents data that was labeled as UMHP in prior years.

Source: Maryland Department of Health

VBP Sunset and PHIP Implementation

Two issues have led to concerns about the VBP program. First, MCO regulations adopted at the federal level require actuarial soundness not on a programwide basis but on an individual MCO basis. While this interpretation has been disputed, MDH reports that CMS has confirmed that this is the intent of the rule. To the extent that rates are set at the bottom of the rate range, disincentives in VBP would take an individual MCO below an actuarially sound level. As a result, VBP cannot operate as currently constituted. In calendar 2018 with rates at the bottom of the range, Medicaid announced the program would be incentive only. However, because regulations were not changed, this ruling was contested, and ultimately, Medicaid settled with three MCOs on a percentage of the secondary distribution that would have been owed.

Second, the structure of the secondary distribution can, if significant disincentive payments are collected, result in substantial secondary payouts to smaller MCOs as well as MCOs with relatively poor outcomes in the program receiving more based on their share of overall enrollment. In response to longstanding concerns about the secondary distribution, the BRFA of 2020 restructured the VBP program to allocate the secondary distribution as follows:

- 40% to the four highest performing MCOs, except that MCOs with net disincentives could not collect funding;

- 25% to MCOs based on improvement to be used to further target performance improvement;

- 25% for health improvement programs in HealthChoice; and

- 10% to establish a reserve in the HealthChoice Performance Incentive Fund, although once the fund balance exceeds $5 million, this funding would be distributed between the other funding priorities.

Medicaid is replacing VBP with the HealthChoice PHIP, effective January 1, 2022. The PHIP includes an incentive-only structure. Under this type of program, the level of incentives available will be based on the amount provided in the budget for each fiscal year. The fiscal 2023 allowance includes $35 million ($11.8 million in general funds and $23.2 million in federal funds) for this program in its first year.

The PHIP will continue the practice of awarding incentive payments to MCOs in two rounds. However, it does include some of the changes to VBP from the BRFA of 2020, such as adding improvement-based payments. The new program as described in regulation would allow MCOs to receive performance incentives or improvement incentives in the first round.

- ***Performance Incentive Payments:*** MCOs could earn payments for achieving incentives ranked from "strong performance" (in which a measure is between the fiftieth and seventy-fourth percentile of national HEDIS performance or Maryland MCO performance for

non-HEDIS measures) to "superlative performance" (in which an MCO is at or above the ninetieth percentile of national HEDIS performance or Maryland MCO performance for non-HEDIS measures). Depending on the incentive category achieved, MCOs would earn higher or lower incentive allocations, and MCOs earning a score below the fiftieth percentile would not be eligible for a round one performance payment for that measure.

- ***Improvement Incentive Payments:*** If an MCO (1) demonstrates improvement of at least 0.5 percentage points for a measure over the prior year and (2) reports a score at least in the fiftieth percentile of national HEDIS performance or Maryland MCO performance for non-HEDIS measures, then they may also earn a share of the incentive allocation for that measure.

MDH would implement a second round of PHIP payments if there are remaining funds unallocated after the initial round. However, MCOs would only be eligible for a secondary payment if they earned above 80% of possible round one incentives and did not have any penalties applied for failure to meet HEDIS monitoring policies.

MDH should discuss the transition between the PHIP and VBP, particularly in calendar 2021.

Operating Budget Recommended Actions

1. Add the following language to the general fund appropriation:

, provided that $1,000,000 of this appropriation made for the purpose of administration in the Office of the Deputy Secretary for Health Care Financing may not be expended until the Maryland Department of Health submits quarterly reports on the Medicaid redetermination process following the termination of the national declaration of a COVID-19 public health emergency. Each report shall include the following data on a monthly basis and divided by eligibility category:

(1) the number of individuals disenrolled;

(2) the number of new individuals enrolled;

(3) the number of individuals re-enrolling in Medicaid after temporarily losing benefits, including the average length of time to re-enroll after the initial loss of coverage; and

(4) the number of disenrollments by reason for disenrollment, identifying disenrollments due to failure to apply for recertification, missing information/verifications, income too high, and other common reasons for disenrollment.

The first report shall be submitted by November 1, 2022, and the other reports shall be submitted quarterly thereafter. The funds may be released in $250,000 increments related to the submission of each quarterly report. The budget committees shall have 45 days from the date of the receipt of each report to review and comment. Funds restricted pending the receipt of the reports may not be transferred by budget amendment or otherwise to any other purpose and shall revert to the General Fund if the report is not submitted to the budget committees.

Explanation: This language restricts funds budgeted for administrative purposes until the Maryland Department of Health (MDH) submits quarterly reports with data and status updates related to the eligibility redetermination process.

Information Request	**Author**	**Due Date**
Quarterly reports with data and status updates related to redetermination	MDH	November 1, 2022 February 1, 2023 May 1, 2023 June 30, 2023

2. Add the following language to the general fund appropriation:

Further provided that $250,000 of this appropriation made for the purpose of administration in the Office of the Deputy Secretary for Health Care Financing may not be expended until the Maryland Department of Health submits a report on home- and community-based services (HCBS) expansion. The report shall include the following information with federal claims and spending data disaggregated by administration, including the Behavioral Health Administration, the Developmental Disabilities Administration, and the Medical Care Programs Administration:

(1) the amount of federal funds claimed through the 10% enhanced federal match for HCBS expenditures from April 1, 2021, to March 31, 2022, as authorized in the American Rescue Plan Act, including secondary federal funds claimed and any associated State funds accounted for separately;

(2) an update on uses of the HCBS enhanced federal match by fiscal year, including a timeline for spending the funds and the status of Centers for Medicare and Medicaid Services approval; and

(3) specific programmatic recommendations on ways to claim Medicare savings to apply to costs for HCBS waiver expansion;

The report shall be submitted by November 1, 2022, and the budget committees shall have 45 days from the date of the receipt of the report to review and comment. Funds restricted pending the receipt of a report may not be transferred by budget amendment or otherwise to any other purpose and shall revert to the General Fund if the report is not submitted to the budget committees.

Explanation: The committees are interested in receiving federal claims and spending data accounting for enhanced federal matching funds authorized in the American Rescue Plan Act for HCBS spending from April 1, 2021, to March 31, 2022. This language restricts funds budgeted for administrative purposes until the Maryland Department of Health (MDH) submits a report with spending data and other information on HCBS expansion efforts.

Information Request	**Author**	**Due Date**
Report on HCBS expansion	MDH	November 1, 2022

3. Add the following language:

All appropriations provided for program M00Q01.03 Medical Care Provider Reimbursements are to be used only for the purposes herein appropriated, and there shall be no budgetary transfer to any other program or purpose except that funds may be transferred to program M00Q01.07 Maryland Children's Health Program. Funds not expended or transferred shall revert to the General Fund.

Explanation: This annual budget language restricts Medicaid provider reimbursements to that purpose only and prevents budgetary transfers to any program except the Maryland Children's Health Program.

4. Adopt the following narrative:

Managed Care Organization (MCO) Risk Corridor Settlements: Given the uncertainty around service utilization trends during the COVID-19 pandemic, the Maryland Department of Health (MDH) entered into risk corridor agreements with MCOs for calendar 2020 and 2021. Under these two-sided agreements, the MCOs and State share in any savings or losses depending on revenues exceeding or falling below certain expenditure levels. MDH is expected to recover some amount of savings based on calendar 2020 medical loss ratio results, while the department's initial estimates in calendar 2021 would not trigger a risk corridor. The committees request that MDH submit a report detailing:

- calendar 2020 risk corridor results by individual MCO;
- the final State recovery amount resulting from the calendar 2020 risk corridor (broken out by federal and State shares);
- the timeline and mechanism for recoupment of calendar 2020 recoveries; and
- calendar 2021 risk corridor results programwide.

The report should also include a discussion of whether risk corridor agreements are likely necessary due to the COVID-19 pandemic in calendar 2023.

Information Request	**Author**	**Due Date**
MCO risk corridor settlements	MDH	July 1, 2022

5. Adopt the following narrative:

Community First Choice (CFC) Program and Home- and Community-based Options (Community Options) Waiver Financial and Registry Data: Recent efforts to expand home- and community-based services have led to significant increases in CFC program expenditures, including spending for the Community Options waiver. The committees request that the Maryland Department of Health (MDH) submit quarterly reports on spending in CFC, disaggregating Community Options waiver spending. The reports should include monthly enrollment, utilization, and cost data that aligns with actual budget expenditures under the CFC program, and the initial report should include data that reconciles to actual spending in fiscal 2021 and 2022. Each report should also provide:

- an update on the number of Community Options waiver slots filled of the 800 newly funded slots across fiscal 2022 and 2023;
- the current status of the Community Options waiver registry, including a discussion of any changes to outreach and methodology for registry operation;
- the number of new or transferred positions to the Community Options waiver in fiscal 2022 and 2023 that have been filled; and
- a description of how the new filled positions support filling waiver slots and screening individuals off of the waiver registry more efficiently.

Information Request	**Author**	**Due Date**
Report on CFC program and Community Options waiver financial and registry data	MDH	August 1, 2022 November 1, 2022 February 1, 2023 May 1, 2023

6. Add the following language:

<u>All appropriations provided for program M00Q01.07 Maryland Children's Health Program are to be used only for the purposes herein appropriated, and there shall be no budgetary transfer to any other program or purpose.</u>

Explanation: This budget language restricts funding in the Maryland Children's Health Program to that purpose only and prevents budgetary transfers.

		Amount Reduction	
7.	Delete a fiscal 2022 federal fund deficiency appropriation under Medicaid for the enhanced federal matching funds for home- and community-based services as a technical correction. These funds are double budgeted as a budget amendment has already added the appropriation for this purpose.	$ 37,427,995	FF
8.	Delete a fiscal 2022 federal fund deficiency appropriation under the Maryland Children's Health Program for the enhanced federal matching funds for home- and community-based services as a technical correction. These funds are double budgeted as a budget amendment has already added the appropriation for this purpose.	350,973	FF
	Total Reductions to Fiscal 2022 Deficiency	**$ 37,778,968**	

Updates

1. Medicaid Expenditures on Abortion

Language attached to the Medicaid budget since 1979 authorizes the use of State funds to pay for abortions under specific circumstances. Specifically, a physician or surgeon must certify that, based on his or her professional opinion, the procedure is necessary. Similar language has been attached to the appropriation for MCHP since its advent in fiscal 1999. Women eligible for Medicaid solely due to a pregnancy do not currently qualify for a State-funded abortion. **Exhibit 16** provides a summary of the number and cost of abortions by service provider in fiscal 2019 through 2021.

Exhibit 16
Abortion Funding under the Medical Assistance Program*
Three-year Summary
Fiscal 2019-2021

	Performed under 2019 State and Federal Budget Language	Performed under 2020 State and Federal Budget Language	Performed under 2021 State and Federal Budget Language
Abortions	9,676	9,909	10,163
Total Cost ($ in Millions)	**$6.1**	**$6.6**	**$6.8**
Average Payment Per Abortion	$626	$663	$668
Abortions in Clinics	7,490	7,572	7,470
Average Payment	$433	$467	$469
Abortions in Physicians' Offices	1,773	1,915	2,344
Average Payment	$972	$989	$938
Hospital Abortions – Outpatient	409	421	349
Average Payment	$2,592	$2,691	$3,119
Hospital Abortions – Inpatient	4	1	0
Average Payment	$6,443	$10,931	$0
Abortions Eligible for Joint Federal/State	0	0	0

* Data for fiscal 2019 and 2020 includes all Medicaid-funded abortions performed during the fiscal year, while data for fiscal 2021 include all abortions for which a Medicaid claim was filed through November 2021. Providers are allowed to submit fee-for-service claims up to 12 months after the date of service; therefore, Medicaid may receive additional claims for abortions performed during fiscal 2021. For example, in fiscal 2021, 45 additional claims from fiscal 2020 were paid after November 2020. This explains differences in the fiscal 2020 data reported in this analysis compared to prior Medicaid budget analyses.

Source: Maryland Department of Health

Exhibit 17 indicates the reasons abortions were performed in fiscal 2021 according to the restrictions in the federal budget and State budget bill.

Exhibit 17
Abortion Services by Reason
Fiscal 2021

I. Abortion Services Eligible for Federal Financial Participation
(Based on restrictions contained in the federal budget.)

Reason		Number
1.	Life of the woman endangered.	0
	Total Received	**0**

II. Abortion Services Eligible for State-only Funding
(Based on restrictions contained in the fiscal 2021 State budget.)

Reason		Number
1.	Likely to result in the death of the woman.	0
2.	Substantial risk that continuation of the pregnancy could have a serious and adverse effect on the woman's present or future physical health.	530
3.	Medical evidence that continuation of the pregnancy is creating a serious effect on the woman's mental health and, if carried to term, there is a substantial risk of a serious or long-lasting effect on the woman's future mental health.	9,611
4.	Within a reasonable degree of medical certainty that the fetus is affected by genetic defect or serious deformity or abnormality.	20
5.	Victim of rape, sexual offense, or incest.	2
Total Fiscal 2021 Claims Received through November 2021		**10,163**

Source: Maryland Department of Health

Appendix 1
2021 *Joint Chairmen's Report* Responses from Agency

The 2021 JCR requested that MDH prepare six reports. Electronic copies of the full JCR responses can be found on the DLS Library website.

- ***Report on Enhanced Federal Matching Funds on HCBS:*** Further discussion of MDH's current spending plan for the 10% eFMAP authorized in the ARPA for HCBS can be found in the fiscal 2022 budget discussion of this analysis.

- ***Calendar 2020 MCO Risk Corridor Settlements:*** Due to the uncertainty of health care utilization trends during the COVID-19 pandemic, MDH entered a two-sided risk corridor agreement with MCOs in calendar 2020 and 2021. The department's report submitted on July 1, 2021, is discussed in the fiscal 2022 budget discussion of this analysis.

- ***HCBS Waiver Services Expansion:*** As of February 20, 2022, MDH had not submitted the requested report.

- ***Collaborative Care Pilot Updates:*** Chapters 683 and 684 of 2018 required that MDH establish a Collaborative Care Model Pilot Program to integrate somatic and behavioral health services through three primary care sites. MDH used a competitive application process to select the sites with funds ranging from $225,000 in the first fiscal year to $550,000 annually for fiscal 2021 through 2023. The department estimates that expanding the model statewide would cost between $18.8 million and $32.4 million annually. Initial findings from the pilot suggest that the sites improved clinical outcomes, and MDH recommends continuing the pilot program through fiscal 2023 then completing an evaluation.

- ***Report on IMD Designation:*** MDH's response to the fiscal 2021 Budget Bill language on IMD designation is discussed in Issue 1 of this analysis.

Appendix 2
Medicaid Management Information System II
(Medicaid Enterprise Systems Modular Transformation)
Major Information Technology Project
Maryland Department of Health

New/Ongoing: Ongoing								
Start Date: July 1, 2016				**Est. Completion Date: September 30, 2027**				
Implementation Strategy: Agile								
($ in Millions)	**Prior Year**	**2022**	**2023**	**2024**	**2025**	**2026**	**Remainder**	**Total**
GF	$15.193	$12.351	$19.143	$20.883	$19.258	$12.928	$29.714	$129.470
FF	113.800	82.938	118.445	27.145	87.729	58.893	171.039	659.989
Total	**$128.993**	**$95.289**	**$137.588**	**$48.028**	**$106.986**	**$71.821**	**$200.753**	**$789.459**

- ***Project Summary*:** This information technology (IT) project replaces Medicaid's antiquated and inflexible legacy information system with a modern Medicaid Management Information System (MMIS). MDH has completed a Medicaid IT Architecture self-assessment of its business operations and subsequently developed a roadmap for procurement, replacement, and implementation of various modular systems, including:

  - Customer Relationship Management, which will be renamed Business Process Reengineering;
  - Decision Support System/Data Warehouse;
  - Pharmacy Point-of-sale Electronic Claims Management System;
  - Behavioral Health Administrative Service Organization (BHASO);
  - TierPoint Migration of the Electronic Data Interchange Transaction Processing System (EDITPS);
  - eMedicaid migration to the Maryland Total Human-services Information Network (MD THINK);
  - No Wrong Door project integrating application transfers between Maryland Health Connection and eligibility and enrollment;
  - Non-emergency Medical Transportation; and
  - other business processes, such as provider and financial management, enterprise security, surveillance and utilization reviews, and core MMIS services.

- ***Need:*** The legacy MMIS was installed in 1995 and is unable to meet the needs of Maryland's increasingly complex Medicaid program. Three key goals of the new modular systems are real-time and automated adjudication of claims (part of core MMIS implementation), a new financial management system to automate the federal fund claims process, and improved reporting capability. MDH will also integrate services through the MD THINK cloud-based platform as applicable.

- ***Observations and Milestones:*** A new roadmap outlining the systems to be modernized and timeline for the project was released in May 2021. Under the new roadmap, there will be three phases and project completion has been pushed out from calendar 2025 to 2027. As of July 2021, MDH finalized a Program Management Office solicitation for consulting services.

  Overall, MDH is behind schedule for the project but reported in the fiscal 2023 Information Technology Project Request (ITPR) that it is currently on track for Business Process Reengingeering, Division of Recoveries and Financial Services, CMS Interoperability Rule, Dental Administrative Service Organization, EDITPS, Eligibility and Enrollment waivers, No Wrong Door project, and Utilization Control Agency.

- ***Changes:*** The BHASO component went live January 2020 with limited functionality and resulted in significant provider payment issues that will take several years to resolve. MDH is still working with Optum to complete development, manage defect releases, and develop a path to CMS certification. The pharmacy point-of-sale module go-live date was missed, which required an emergency contract extension for the current system. This module is at further risk of delay because the FlexRx Rebates user acceptance testing was pushed back to November 2021.

- ***Concerns:*** The BHASO module go-live was a complete failure, with defects continuing to be resolved. Further discussion of the difficulties with the BHASO transition can be found in the MDH BHA – M00L analysis. The pharmacy point-of-sale module has also been delayed, and a new roadmap and timeline have been necessary after the COVID-19 pandemic further delayed procurements and work on some modules. Lack of choice in vendors among the Medicaid IT field also remains a significant risk.

- ***Other Comments:*** CMS may approve 90% federal financial participation for design, development, or installation of MMIS costs. MDH completed the required assessment and documentation to receive enhanced federal fund participation for eligible expenses under the MMIS II project.

Appendix 3
Long Term Services and Supports Tracking System
Major Information Technology Project
Maryland Department of Health

New/Ongoing: Ongoing								
Start Date: March 18, 2013				**Est. Completion Date:** Final development anticipated during fiscal 2025				
Implementation Strategy: Waterfall and Agile mix								
($ in Millions)	**Prior Year**	**2022**	**2023**	**2024**	**2025**	**2026**	**Remainder**	**Total**
GF	$27.751	$5.393*	$5.393	$5.393	$5.393	$16.180	$0.000	$65.505
FF	129.063	20.084	29.648	29.648	29.648	88.944	0.000	327.034
Total	**$156.814**	**$25.477**	**$35.041**	**$35.041**	**$35.041**	**$105.124**	**$0.000**	**$392.539**

*Includes a proposed deficiency appropriation of $3.116 million.

- ***Project Summary:*** The Long Term Services and Supports (LTSS) tracking system is an integrated care management system for long-term care services that includes a standardized assessment instrument, in-home services verification, and real-time medical and service information. Initially developed to respond to various long-term care program opportunities under the ACA, LTSS has been incorporating other modules to cover all HCBS under Medicaid, including services to the developmentally disabled.

  Need: This IT project integrates many common functions across HCBS programs and allows the State to meet federal requirements for electronic visit verification of personal care services.

- ***Observations and Milestones:*** MDH reported that it was midway through the design phase of the long-term implementation of Model Waiver functionality. The interface between LTSS, Eligibility and Enrollment functions, and MD THINK was also operational and rolled out to a minimum of 10 counties. As of the submission of the fiscal 2023 ITPR, MDH expected to rollout the integrated LTSS interface to the remaining 14 jurisdictions by November 2021. An MDH Office of the Inspector General review found that LTSS did not sufficiently control access to protected health information, so a significant upgrade was implemented to restrict user access to only those who have been assigned.

- ***Concerns:*** The highest risk for the LTSS project remains engagement with, and adoption by, stakeholder groups. Funding adequacy is now a slightly higher risk, as the fiscal 2023 budget plan includes a proposed deficiency appropriation of $3.1 million in general funds to cover an anticipated shortfall.

- ***Other Comments:*** MDH received approval for enhanced federal financial participation for certain costs associated with this project. The department anticipates that this federal support will continue through at least federal fiscal 2022.

Appendix 4
Federal Poverty Guidelines as of January 12, 2022
(48 Contiguous States Excluding Alaska and Hawaii)

Household/ Family Size	25%	50%	75%	100%	125%	133%	135%	138%*	185%	200%	225%	250%	275%	300%**
1	$3,398	$6,795	$10,193	$13,590	$16,988	$18,075	$18,347	$18,754	$25,142	$27,180	$30,578	$33,975	$37,373	$40,770
2	4,578	9,155	13,733	18,310	22,888	24,352	24,719	25,268	33,874	36,620	41,198	45,775	50,353	54,930
3	5,758	11,515	17,273	23,030	28,788	30,630	31,091	31,781	42,606	46,060	51,818	57,575	63,333	69,090
4	6,938	13,875	20,813	27,750	34,688	36,908	37,463	38,295	51,338	55,500	62,438	69,375	76,313	83,250
5	8,118	16,235	24,353	32,470	40,588	43,185	43,835	44,809	60,070	64,940	73,058	81,175	89,293	97,410
6	9,298	18,595	27,893	37,190	46,488	49,463	50,207	51,322	68,802	74,380	83,678	92,975	102,273	111,570
7	10,478	20,955	31,433	41,910	52,388	55,740	56,579	57,836	77,534	83,820	94,298	104,775	115,253	125,730
8	11,658	23,315	34,973	46,630	58,288	62,018	62,951	64,349	86,266	93,260	104,918	116,575	128,233	139,890
9	12,838	25,675	38,513	51,350	64,188	68,296	69,323	70,863	94,998	102,700	115,538	128,375	141,213	154,050
10	14,018	28,035	42,053	56,070	70,088	74,573	75,695	77,377	103,730	112,140	126,158	140,175	154,193	168,210
11	15,198	30,395	45,593	60,790	75,988	80,851	82,067	83,890	112,462	121,580	136,778	151,975	167,173	182,370
12	16,378	32,755	49,133	65,510	81,888	87,128	88,439	90,404	121,194	131,020	147,398	163,775	180,153	196,530
13	17,558	35,115	52,673	70,230	87,788	93,406	94,811	96,917	129,926	140,460	158,018	175,575	193,133	210,690
14	18,738	37,475	56,213	74,950	93,688	99,684	101,183	103,431	138,658	149,900	168,638	187,375	206,113	224,850

*The Affordable Care Act expanded Medicaid coverage to individuals with household incomes below 138% of the federal poverty level.
**The income eligibility threshold for the Maryland Children's Health Program is 300% of the federal poverty level.

Source: U.S. Department of Health and Human Services; Department of Legislative Services

Appendix 5
Object/Fund Difference Report
MDH – Medical Care Programs Administration

Object/Fund	FY 21 Actual	FY 22 Working Appropriation	FY 23 Allowance	FY 22 - FY 23 Amount Change	Percent Change
Positions					
01 Regular	608.90	615.00	611.00	-4.00	-0.7%
02 Contractual	71.98	111.41	114.83	3.42	3.1%
Total Positions	**680.88**	**726.41**	**725.83**	**-0.58**	**-0.1%**
Objects					
01 Salaries and Wages	$ 53,166,264	$ 55,020,511	$ 56,808,431	$ 1,787,920	3.2%
02 Technical and Special Fees	4,706,659	5,305,492	6,754,654	1,449,162	27.3%
03 Communication	831,599	996,069	867,240	-128,829	-12.9%
04 Travel	25,322	155,524	208,820	53,296	34.3%
06 Fuel and Utilities	6,395	7,683	7,049	-634	-8.3%
07 Motor Vehicles	0	5,564	2,438	-3,126	-56.2%
08 Contractual Services	10,748,901,748	11,665,994,006	11,953,314,756	287,320,750	2.5%
09 Supplies and Materials	129,346	293,222	194,338	-98,884	-33.7%
10 Equipment – Replacement	81,362	93,149	104,568	11,419	12.3%
11 Equipment – Additional	472	0	2,200	2,200	N/A
13 Fixed Charges	194,862	216,141	265,437	49,296	22.8%
Total Objects	**$10,808,044,029**	**$ 11,728,087,361**	**$ 12,018,529,931**	**$ 290,442,570**	**2.5%**
Funds					
01 General Fund	$ 2,604,898,694	$ 3,458,436,956	$ 3,945,440,410	$ 487,003,454	14.1%
03 Special Fund	1,020,352,628	727,461,369	755,056,191	27,594,822	3.8%
05 Federal Fund	7,089,095,140	7,472,489,007	7,235,724,618	-236,764,389	-3.2%
09 Reimbursable Fund	93,697,567	69,700,029	82,308,712	12,608,683	18.1%
Total Funds	**$10,808,044,029**	**$ 11,728,087,361**	**$ 12,018,529,931**	**$ 290,442,570**	**2.5%**

Note: The fiscal 2022 working appropriation does not include funds allocated through Supplemental Budget No. 1, deficiency appropriations, or targeted reversions. The fiscal 2022 working appropriation and fiscal 2023 allowance do not include funding for statewide personnel actions budgeted in the Department of Budget and Management.

Appendix 6
Fiscal Summary
MDH – Medical Care Programs Administration

Program/Unit	FY 21 Actual	FY 22 Wrk Approp	FY 23 Allowance	Change	FY 22 - FY 23 % Change
01 Deputy Secretary for Health Care Financing	$ 8,194,494	$ 12,101,055	$ 31,311,292	$ 19,210,237	158.7%
02 Enterprise Technology – Medicaid	16,262,656	16,108,677	15,441,876	-666,801	-4.1%
03 Medical Care Provider Reimbursements	10,351,135,933	11,217,718,963	11,447,286,733	229,567,770	2.0%
04 Office of Health Services	56,671,723	54,810,270	46,503,135	-8,307,135	-15.2%
05 Office of Finance	6,378,567	7,149,581	7,545,431	395,850	5.5%
07 Maryland Children's Health Program	291,172,580	289,934,514	295,487,877	5,553,363	1.9%
08 Major Information Technology Development	53,068,894	104,040,427	148,092,851	44,052,424	42.3%
09 Office of Eligibility Services	14,402,992	14,352,990	14,838,548	485,558	3.4%
11 Senior Prescription Drug Assistance Program	10,756,190	11,870,884	12,022,188	151,304	1.3%
Total Expenditures	**$10,808,044,029**	**$11,728,087,361**	**$12,018,529,931**	**$ 290,442,570**	**2.5%**
General Fund	$ 2,604,898,694	$ 3,458,436,956	$ 3,945,440,410	$ 487,003,454	14.1%
Special Fund	1,020,352,628	727,461,369	755,056,191	27,594,822	3.8%
Federal Fund	7,089,095,140	7,472,489,007	7,235,724,618	-236,764,389	-3.2%
Total Appropriations	**$10,714,346,462**	**$11,658,387,332**	**$11,936,221,219**	**$ 277,833,887**	**2.4%**
Reimbursable Fund	$ 93,697,567	$ 69,700,029	$ 82,308,712	$ 12,608,683	18.1%
Total Funds	**$10,808,044,029**	**$11,728,087,361**	**$12,018,529,931**	**$ 290,442,570**	**2.5%**

Note: The fiscal 2022 working appropriation does not include funds allocated through Supplemental Budget No. 1, deficiency appropriations, or targeted reversions. The fiscal 2022 working appropriation and 2023 allowance do not include funding for statewide personnel actions budgeted in the Department of Budget and Management.